Maternal and Child Health Services
Title V Block Grant

State Narrative for Virgin Islands

Application for 2011
Annual Report for 2009

Document Generation Date: Saturday, September 18, 2010

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

By submission of the Title V Block Grant Application for 2010-2011, The Virgin Islands Department of Health (VI DOH) assures compliance with all requirements established by OBRA '89 (PL 104-193, 1996). Funds allotted to VI will only be used for addressing the identified meeds of women, infants, children and adolescents, including those with special health care needs and their families. VI DOH further assures proper management and implementation of the action plan as described in the application. The alloted funds will be fairly distributed across all MCH population groups in accordance to the mandate (30-30-10). These funds will be used only to carry out the purpose of Title V programs and activities, consistent with Section 508.

Under no circumstances will Title V Block Grant funds be used for construction or the purchase of land.

Additionally, we certify that services will be rendered in a smoke-free environment, to provide a drug-free workplace in accordance with 45 CFR Part 76, and to comply with the prohibition of using federal funds to support any activity regarding lobbying or it appearance to.

Signed copies of the Assurances and Certifications required for this application are located at the MCH & CSHCN Program Administrative Office located on St. Thomas, VI.

These forms are available upon request by USPS Express Mail service.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

Public input into the Block Grant Application is an on-going process. The Virgin Islands Department of Health invites public review and input relative to planning for and writing the Title V Five-Year Block Grant Application and Program Plan for the Maternal Child Health & Children With Special Health Care Needs (MCH & CSHCN) Program. Notices are printed in local newspapers and aired on cable television public service announcements on both islands annually providing information on availability of the block grant application for public review and comment. Public input is also solicited by placing the application in selected community partner agencies, with a special focus on those who provide advocacy and outreach services to children with special health care needs and their families. Response forms accompany each copy with options to accept the application as written or accept with changes and / or additions.

Public participation in these reviews has not been as great as anticipated. The program makes

every effort to encourage individuals who use program services to voice their concerns or ideas regarding the quality and effectiveness of the services received. These families rarely would attend a formal meeting or focus group concerning the Title V Program.

Focus groups were scheduled consisting of members of the MCH Advisory Council which includes parents, consumers and individuals from several public and non-profit agencies who reviewed and endorsed the application prior to submission. In addition to review by members of the VI Alliance for Primary Care, and the MCH Advisory Council, individuals from several other agencies and organizations requested copies of the document this past fiscal year.

Comments and suggestions this year included:
-Overall, good application. Need to continue efforts for data linkages and collaboration with relevant agencies.
-Plan to address childhood obesity.
-Increased focus on adolescent health care needs.
-Addressing the issue of autism spectrum disorders.
-Better coordination of services for children with special health care needs; what gaps are identified and how are they being addressed.
-Providing more public information on the program and the services offered
-Strengthening of programs and community based organizations referral and feedback system. What mechanisms are already in place and how can they be enhanced for better results.

An attachment is included in this section.

II. Needs Assessment

In application year 2011, the 2010 Needs Assessment will be attached to this Section II.

An attachment is included in this section.

C. Needs Assessment Summary

Summary of 2010-2015 USVI MCH Block Grant Needs Assessment

Perhaps the most important implications of this needs assessment relates back to two strategies: 1) Increasing services to the MCH population in all areas of primary and preventive care, and 2) Collaborating with other agencies providing services to the MCH population to increase the access to the health care system. These strategies must be done in conjunction with health care providers as critical partners. Increasing availability and access to primary and specialty care, although important, will not improve health outcomes unless the services provided are also developmentally appropriate and are engaging in a way that is likely to lead to behavior change. Providers alone cannot accomplish this, but by partnering with other key stakeholders in improving adolescent health, they can leverage their influence in positive ways. The Institute of Medicine has focused on the need to prepare a MCH workforce better prepared to address the health needs of adolescents. Although resources are limited, the Rochester LEAH program that developed and analyzed the Adolescent Health survey is interested in addressing this very palpable need in the USVI, including developing an educational program for providers, possibly using advanced telemedicine technology available at the University of Rochester.

During this cycle of the 5-year Needs Assessment process, almost 300 teenagers were surveyed using reliable and valid tools designed to assess the health and health needs for a representative sampling of adolescents living in the USVI. Gathering information on this particular population was stressed as it is a segment that has historically been underrepresented in the assessment process. The key findings represent both challenges and opportunities. The health challenges include obesity due to the combination of poor nutrition with low intake of readily available fruits and vegetables and low level of physical activity, even in many school settings. A large burden of asthma and diabetes are probably related to obesity, but deserve attention because on their own they can cause serious, and expensive, health risks. For example, children and adolescents with complicated diabetes are sometimes flown to Puerto Rico to see a pediatric endocrinologist, since none is available in the USVI. With respect to health risk behaviors, marijuana and alcohol use are much more concerning than tobacco. Sexual health risks for both STI and pregnancy are a concern because of the reported behaviors and were also recognized as topics that need to be addressed by youth themselves.

It is clear that for many youth health risk behaviors begin before their teenage years. Thus, preventive efforts need to begin earlier, in childhood or before. Also, the issue of disparities became evident insofar as youth at a private school had many more opportunities to engage in physical education in school than did some youth in public schools. This may be related to socio-economic status, which is known to confer some degree of protection in itself, but community-based, youth-development approaches that reach a broad array of youth may be more beneficial than school-based interventions. In addition, youth reported different levels of rules and rule enforcement at school and at home. Having consistent, pro-social messages across all of their environments about rules tends to be associated with youth having more protective factors and fewer risk behaviors. The MCH community can have an important role in this regard, because a majority of respondents found that having talked about topics with a health provider was helpful or very helpful. This is likely to apply to parents and parenting, as well. Primary and specialty care providers are influential providing consistent messages to youth and their parents, with specific, concrete suggestions to modify behavior using motivational interviewing techniques. Again,

consistency responding to adolescent behaviors at home and in schools is likely to be helpful.

Reaching our populace with the requisite services is a collaborative effort with programs such as Immunization Program who through their mandate welcome improved immunization of all children against vaccine preventable diseases. In addition, linkages with agencies providing services to adolescents are an ongoing activity, e.g., administering comprehensive health behavior survey as many are cooperative and committed to improved health habits for the adolescent population. Then, there is public, proactive campaign to reduce the burden of illness due to obesity in children and adults on all islands and activities linked to this objective are the department's broad-base community education and outreach campaign; MCH providers counsel of clients on health behaviors linked to obesity; Public Health Week and year round activities; and the CBOs programs for children, youth and families to further reduce obesity among this population.

In reviewing the Title V performance indicators, the Virgin Islands has several areas that need improvement In the provision of prenatal care services. The 2010 Prenatal Care Needs Assessment Survey provided the baseline data considered in the determination of priority areas of this prenatal health care plan. Targets to be attained during the 5-year period were determined to be most appropriate and feasible. The VI Maternal Child Health Program will work to address the identified priority needs in the next 5 years. In the face of these challenges, it will strive to develop and implement appropriate interventions to address these concerns.

III. State Overview

A. Overview

The Maternal and Child Health Block Grant is authorized by Title V of the Social Security Act, as amended by the Omnibus Budget Reconciliation Act of 1989, Public Law 101-239. The Block Grant Funds assist the Virgin Islands in maintaining and strengthening its efforts to improve the health of all mothers, infants, and children, including children with special health care needs. The U.S. Virgin Islands Department of Health is the official Title V agency for the Virgin Islands.

The U.S. Virgin Islands is an unincorporated territory of the United States, with a local government structure defined by the federal Revised Organic Act of 1954, as amended. Internal political affairs are under the jurisdiction of an elected governor and a 15-member unicameral legislature. In addition to the U.S. District Court, the U.S. Virgin Islands has its own system of local courts, including a Superior Court and Supreme Court.
USVI residents are citizens of the United States. They elect the Governor, a fifteen member Legislature, and a non-voting Delegate to the U.S. House of Representatives. This official can vote in committee, but does not have a vote on legislation in the full House of Representatives. USVI residents contribute to Social Security, serve in the U.S. military, and can be called for military service. They do not pay federal income taxes and or vote in U.S. presidential elections. Residents are eligible to participate in federal government programs, but levels of assistance are usually lower than those provided for people living in the 50 states and the District of Columbia.

Geography: The Territory of the U.S. Virgin Islands (USVI) is a collection of four major islands-St. Croix, St. Thomas, St. John, Water Island, and 70 smaller islets and cays. The location of the Territory is in the Caribbean Sea at the eastern end of the Greater Antilles and the northern end of the Lesser Antilles. The Territory is 1,600 miles south southeast of New York; 1,100 miles east southeast of Miami; and 100 miles southeast of San Juan.

Of the many islands and cays comprising the U.S. Virgin Islands, only four are of economic or clinical significance at the present time. The largest, St. Croix, is 82.9 square miles, mostly flat and therefore, the most suitable for intensive economic development. It has two main towns-Christiansted, the larger of the two on the east, and Frederiksted, on the west.

Forty miles due north, St. Thomas is approximately 32 square miles and has rugged mountains that rise sharply from the sea to heights of up to 1,500 square feet. The population density is 1,543.8 persons per square mile, more than twice that of St. Croix.

A few miles east of St. Thomas lies St. John, offering a similar land and seascape. More than half of the island is designated as a National Park, which has served to preserved much of this island's natural beauty. The main town of Cruz Bay is centrally located.
The fourth isle is Water Island, transferred from the Department of Interior on December 12, 1996. The size of the island is 2-1/2 miles long and 2 miles wide with an area of 500 acres. Water Island is separated from St. Thomas by 2 miles and is close enough to draw life support from.

Health Care Delivery Environment: The Virgin Islands health care system consists of two semi-autonomous hospitals, nursing homes, outpatient clinics, home health care services, hospices, providers, and health educators among others. As a public health department, the goal is to improve the health status of every Virgin Islands resident and to ensure access to quality health care. This includes helping each person live a life free from the threat of communicable diseases, tainted food, and dangerous products. To assist in this mission, activities include regulation of health care providers, facilities, and organizations, and management of direct services to patients where appropriate.

The VI Department of Health (VIDOH) serves the community as both a local and state health

department. It consists of two major divisions -- Public Health Services and Health Promotion & Statistics. Unlike other state health departments on the U.S. Mainland VIDOH provides health services in three community health centers territory wide. In addition, the department has nine boards that license and regulate health care professionals. The central office is located on St. Thomas.

Population: According to the 2000 USVI Census Bureau, the population of the Virgin Islands was 108,612 persons: 53,234 on St. Croix, and 55,378 on St. Thomas/St. John. St. Thomas has the highest population density of 1599 persons per square mile, more than twice that of St. Croix with 642 persons per square mile. St. John has the lowest population density of 214 persons per square mile.
Subsequent annual Community and Household Surveys performed by the University of the Virgin Islands Eastern Caribbean Center reflects that even with overall population increases each year there were small but steady population downward shifts in the birth -- 19 population during the period 2003 -- 2007.
According to the 2007 VI Community Survey (VICS), the USVI population consisted of 114,744 persons; 56,240 on St. Croix and 58,504 on St. Thomas/St. John (Chart 1). This corresponded to a 5.6% increase from the 2000 U.S. Census population of 108,612. The 2007 VICS estimated that males represented 48% (55,269) of the population with females at 52% (59, 475) (Chart 2). 2007 USVI Community Survey (VICS), Eastern Caribbean Center, University of the Virgin Islands.

Population less than 19 years: In 2007, children and youth 0 -- 19 years represented 26.6% (30, 596) of the population, this represents a 4.4% decrease from the total population in that age group (34,556 or 31%) from 2005. This downward trend is further underscored by the data for each of the individual age groups in this population. In 2007 Children under age 5 represented 6% (5,809) of the population a decrease from 7.1% (7,937) in 2005. That same year, children ages 5-9 show a decrease of 5.4% (from 7,866 in 2005 to 7, 440 in 2007) and a decrease in ages 10-14 of 7.9% going from 10,002 in 2005 to 9,209 in 2007. Lastly, adolescents (teens) ages 15-19 also had a decrease of 7% going from 8,751 in 2005 to 8,138 in 2007 (Chart 3).

Population by Age and Percentage: The VI population increased 12.7% overall during the period 2000-2007 (101,809 to 114,744), with a significant decrease evident in the 0 -- 5 and 5-19 age groups (36% and 16.9% respectively). Concurrently, the 20- 59 and 60+ age groups showed increases of 12.8% and 151% respectively (Table 1).

Category	2000	Percent	2005	Percent	2007	Percent	Increase/Decrease	Percent Change
Under Age 5	8,553	7.9%	7,927	7.7%	5,809	5.1%	-3,340	-36%
Ages 5-19	28,540	26.3%	26,619	23.8%	24,787	21.6%	-5,050	-16.9%
Ages 20-59	57,645	53.0%	55,074	49.4%	59,896	52.2%	+6,813	+12.8%
Over Age 60	13,874	12.8%	21,842	19.6%	24,252	21.1%	+14,593	+151%
Total	108,612	100%	111,470	100%	114,744	100%	+12,935	+12.7%

Table 1 (Population by Age and Percentage)

Population by Race / Ethnic Composition: The USVI population primarily consists of persons who are predominantly of African descent, i.e., Black, West Indian or African-American. The district of St. Thomas/St. John holds the highest percentage of people of African descent, while St. Croix holds the highest percentage of Hispanics, whose place of origin may be other Spanish-speaking islands, such as Puerto Rico or the Dominican Republic. The 2000 Census estimated the racial composition of the V.I. population as Black/African American 76.2%, Whites 13.1 %, Other races

7.2% and Two or more races 3.5% (Table 2). The 2007 USVI Community Survey showed a change in these demographics with 88,336 Blacks (76.9%), 10,183 Whites (8.87%) and 16,225 (14.2%) Other races (Table 2).

Year	2000		2005		2007	
Population	Number	Percent	Number	Percent	Number	Percent
Black/African American	82,750	77.3%	90,758	81%	88,336	76.9%
White	14,218	10.6%	9,995	8.9%	10,183	8.87%
Other Races	11,644	12.1%	10,718	9.6%	16,225	14.2%

Table 2 (Population by Race/Ethnicity)

Population by Hispanic or Latino Origin: The 2000 Census estimated 93,416 persons of non-Hispanic origin and 15,196 persons of Hispanic origin (Table 3). According to the 2007 Virgin Islands Community Survey (VICS), by 2007 the number of persons of Hispanic origin increased to 20,850 (18%) of the population (Table 3). The majority of Hispanic residents continue to reside on St. Croix with an estimated population of 13,881 (12%).

	2000		2004		2007	
Population	Number	Percentage	Number	Percentage	Number	Percentage
Hispanic or Latino	15,196	14.0%	22,274	20.0%	20,850	20.0%
-Puerto Rican	8,558	7.0%	12,787	13.3%	11,871	13.3%
-Dominican Republic	6,189	5.7%	6,013	5.4%	6,446	5.4%
-Other Spanish/Hispanic	449	0.4%	1,473	1.3%	2,532	2.21%

Table 3 (Population by Hispanic/Latino origin)
An attachment is included in this section.

B. Agency Capacity

Statutory Authority: The Department of Health functions as both the legislative authorized agency and the territorial public health agency that provides health services for the people of the U.S. Virgin Islands. As set forth by the Virgin Islands Code, Titles 3 and 19, the Department of Health (DOH) has direct responsibility for conducting programs of preventive medicine, including special programs in Maternal and Child Health, Family Planning, Environmental Sanitation, Mental Health, and Drug and Substance Abuse Prevention. DOH also is responsible for health promotion and protection, regulation of health care providers and facilities, and policy development and planning, as well as maintaining the vital statistics for the population.

DOH provides Emergency Medical Services, issues birth and death certificates, performs environmental health services, and conducts health research and surveys. The Department is also responsible for regulating and licensing health care providers and facilities, and assumes primary responsibility for the health of the community in the event of a disaster.

The department employs providers and administrators from every aspect of health care, and manages several programs, both federal and local, to meet the needs of the community/territory.

DOH services are focused towards accomplishing the Department's aim and are administered by 33 activity centers under the following four (4) divisions:

- Office of the Commissioner
- Division of Fiscal Affairs

- Division of Administrative Services and Management
- Preventative Health Services

Public Health Services and Health Promotion & Statistic reach out to many vulnerable residents, including those suffering from HIV/AIDS, mental illness and alcohol and drug dependency. The Bureau of Health Insurance and Medical Assistance Program assists those who cannot afford to pay for needed medical and prescription services.

DOH is a critical component of the Virgin Islands Emergency Support Function-8. Under ESF-8, DOH directs the provision of health services for the Territory in the event of a natural or manmade disaster such as bioterrorism. This role includes coordinating and managing territorial resources to assist victims affected by a disaster.

Goals: The five major performance goals guiding the department encompass all legal mandates as spelled out in the V.I. Code. These goals also address the focus areas for achieving the department's mission.
• Improve health outcomes and access to quality health care
• Provide health education, health promotion and community-based programs
• Enhance mental health and substance abuse services
• Achieve excellence in management practices
• Enforce laws and implement rules and regulations

The Virgin Islands Department of Health (VIDOH) is designated as the agency in the Virgin Islands for administering the Maternal and Child Health and Children With Special Health Care Needs Program (MCH & CSHCN) pursuant to Title 19, Chapter 7, Section 151 of the Virgin Islands Code.
The Maternal and Child Health & Children With Special Health Care Needs (MCH & CSHCN) Program activities are directed at improving and maintaining the health status of women, infants, children, including children with special health care needs and adolescents.

The mission of the MCH & CSHCN Program is to provide the clients and community we serve with accessible, family-centered health services that promote the well-being of children and families in an environment that is inviting, courteous, respectful and values patient confidentiality.

Goals & Objectives: MCH & CSHCN goals are to:
1. Facilitate development of a system of care in the territory that improves the health of women of childbearing age, infants, children, and adolescents through availability of appropriate services that optimize health, growth and development.
2. Assure access to quality health care for women and infants, especially those in low income and vulnerable populations, in order to promote and improve pregnancy and birth outcomes.
3. Improve the health status of children and adolescents to age 21, including those with special health care needs, disabilities or chronic illnesses diagnosed at any time during childhood, through comprehensive, coordinated, family-centered, culturally-competent primary and preventive care.
4. Provide a system of care that eliminates barriers and health disparities for vulnerable and unserved or underserved populations.
5. Provide on-going and continuous evaluation of services and systems throughout the territory related to improving the health status of women, infants, children, children with special health care needs, adolescents and families.
6. Enhance program planning and promote policies that will strengthen MCH infrastructure.
7. Optimize perinatal outcomes through prevention of maternal and infant deaths and other adverse outcomes by promoting preconceptual health, utilization of appropriate services; assuring early entry into prenatal care, and improving perinatal care.

Program Capacity:

The Title V MCH & CSHCN Program administratively is one integrated program within the Department of Health. This allows for more efficient use of limited human and fiscal resources and better collaboration and coordination of services in MCH. The program provides and coordinates a system of preventive and primary health care services for mothers, infants, children and adolescents. These services include prenatal and high-risk prenatal care clinics, postpartum care, well child care that includes immunization, high risk infant and pediatric clinics, care coordination and access to pediatric sub-specialty care for children and adolescents with special health care needs.

The Title V Program looks at various areas and populations to identify underserved MCH individuals in order to commit resources to provide appropriate services for this population. The CQI Team assists in the development of plans and interventions that will support the needed MCH services.

Program staff and our Continuous Quality Improvement (CQI) Team also use their expertise to identify and assess community factors, which may limit the degree of accessibility or availability of MCH services. This is done in conjunction with other community organizations and individuals who also provide similar services to the MCH population.

Child health services promote optimal health, safety, and well-being of all infants, children and adolescents birth to 21 years through preventive practices and strategies along a developmental continuum of growth and development. Services provided include immunization; health education and counseling regarding healthy lifestyle choices; assessment for age appropriate growth and development; monitoring for other underlying health problems; and physical examinations with promotion of healthy child care practices. Referrals are done for oral health care, hearing screening, early intervention services, specialty clinics, and home visits.

The MCH & CSHCN program offers a system of family-centered, coordinated, community-based, culturally competent care, assuring access to child health services that includes medical care, therapeutic and rehabilitative services, care coordination, home visiting, periodic screening, referrals and access to a medical home for children ages birth-21 with disabilities and chronic conditions. Services are provided either directly through Title V or by referral to other agencies and programs that have the capability to provide medical, social, and support services to this population. Public Health Nurses provide assessments, anticipatory guidance, parental counseling, education regarding growth and developmental milestones, proper nutrition practices, immunizations; service / care coordination, and home visiting services to high risk children and their families.

Residents of the territory are not eligible for the Supplemental Security Income (SSI) Program which provides assistive devices, therapeutic or rehabilitative services beyond acute care to children under the age of 16 with disabilities. The Medical Assistance Program does not provide these services, due to the Medicaid Cap imposed by Congress. These services are provided on a limited case by case basis by the Title V Program when required.

Nursery referrals are received on all high-risk newborns who are followed in the MCH & CSHCN clinics in both districts. Infants without any high-risk factors are referred to well child clinics. Infants classified as high-risk or at-risk for a disability due to biological, physiological, or environmental factors or diagnosed with medical conditions are followed in the Infant High Risk clinics. High-risk referral patients are screened to receive a home visit, and family assessment. The primary barrier to the home visiting program is insufficient staff to address the increased needs of the high risk population and requests for home visits.

Screening is conducted by program staff to identify children with developmental delays at the earliest age possible, preferably right after birth. Public health nurses assess the developmental needs of infants and toddlers who are at-risk due to psychosocial or biological risk factors.

The entry point is a referral to the early intervention services program Infants and Toddlers' (Part C of IDEA) service coordinator in order to identify newborns as part of the Infants and Toddlers (Part C) Child-Find system. The lack of qualified professionals on-island and the inability to offer competitive pay for specialized services is a major challenge in providing service to this population.

The Charles Harwood Complex is the principal site for MCH service delivery on St. Croix. This complex houses approximately three hundred employees representing several programs and divisions.

Prenatal services in MCH include: prenatal intake for new patients in which the history, physical, risk assessment, PAP smear, and laboratory referrals are completed; routine follow-up and counseling; teen prenatal; and perinatal/high risk clinic for the management of obstetrically or medically complex cases. Patients with emergencies are referred to the Obstetrical Unit for evaluation and treatment. In-patient deliveries are performed by the hospital's Obstetricians and Midwives.
Diagnostic services, such as ultrasounds and laboratory services, are provided for MCH clients by the hospitals or private facilities. The government does not operate a public health laboratory on either island outside of the hospital facilities.

On St. Croix, prenatal care capacity consists of one Nurse Midwife (vacant), one Obstetrician (1FTE), and a Territorial Perinatologist (.1FTE) at the MCH Clinic. The Ob /Gyn performs the initial medical evaluation, manages medically complicated patients, and provides limited gynecological services. The program is actively recruiting a certified nurse-midwife for both districts. However, salaries and compensation are not comparable to the U.S. mainland creating challenges to filling these positions. On St. Thomas, prenatal services are administered by the Community Health Clinics with one Midwife, one Nurse Practitioner, an Obstetrician, and Perinatologist (.1FTE). The Perinatologist also serves as the Director of Women's Health and conducts clinics at St. Thomas East End Medical Center, Frederiksted Health Center, and at the Morris F. deCastro Clinic on St. John. The St. Thomas / St. John district did not meet the minimum score to be designated as an underserved area. However, the Bureau of Health Professions does allow for individuals eligible for Loan Repayment to be recruited and employed.

Patients are referred to the WIC Special Nutrition Program for dietary assessments, counseling, and follow-up. Dental services are provided at Charles Harwood, on St. Croix, and Community Health Services located at the Roy Lester Schneider Hospital, on St. Thomas and are operated under the auspices of the Division of Dental Health Services. Social workers assist patients with assessments, and applying for Medicaid and other services.

Health services are offered through a system, which employs a variety of health care professionals to include Pediatricians, Nurses, Pediatric Nurse Specialist, Clinical Care Coordinators, Social Workers, Dentists, and Dental Hygienists. Allied health professionals may serve territorially when necessary. As of June 2009, there were 165 physicians licensed to practice in the territory. This includes sixteen (16) Obstetricians, seventeen (17) Pediatricians and twenty-seven (27) General / Family Practitioners. (Source: V.I. Board of Medical Licensure, 2009).

The three main facilities for primary care services are MCH & CSHCN Clinics, PHS 330-Community Health Centers, and hospital-based Community Health Clinics. On St. Thomas MCH's principal facility is located in the western district, the Community Health Clinics at the Roy L. Schneider Hospital serve the mid-island district, and the East End Health Center is located in the east district. On St. Croix, the Frederiksted Health Center is located in the western end of the island, and the MCH & CSHCN principal facility is located in the east at Charles Harwood Complex. On Cruz Bay, St. John, the Morris De Castro Clinic is the site for the MCH & CSHCN monthly Infant/Pediatric high-risk clinic.

Through a series of outreach activities, the MCH & CSHCN Unit identifies children who have health problems requiring intervention, are diagnosed with disabling, or chronic medical conditions, or are at risk. A system of public health nursing, based on specified health districts, is an integral component of providing family-centered, community health services. Sources of child-find include referrals from the Queen Louise Home for Children, Early Childhood Education, Head Start, and Private Providers. Pediatricians, Nurses, Social Workers, a Physical Therapist Assistant, an Occupational Therapist, Audiologists, and Speech Pathologist are the major providers of direct services. The Infants and Toddlers Program employs Service Coordinators on each island.

Hospital newborns with biological, established, or environmental risks are referred to the Infant or Pediatric High Risk clinics based on established criteria. At one year of age, infants are re-assessed and transition to the Well Child Clinic or the Pediatric High Risk Clinic. The Infant and Pediatric High Risk Clinics offer comprehensive, coordinated, family-centered services. Screening is done for developmental delays using the Denver Developmental Screening Tool. Social Workers complete an assessment of the family and home environment, existing support structures, and financial status. A diagnostic assessment and therapeutic plan is developed by the clinical staff. Through an appointment system, children with special health care needs are referred to the sub-specialty clinics by the primary care physician. The Physical Therapist serves territorially. The Speech Pathologist on St. Thomas may travel to St. Croix to provide services and conduct screening.

Population Based-Services: The MCH & CSHCN Program offers three population-based preventive services: immunization services; the newborn genetic / metabolic screening follow-up program; and the newborn hearing screening program. Each is discussed under related Performance Measures.
Newborn hearing screening continued this fiscal year. Discussion under NPM #12 and SPM #5.
Lead screening was initiated on all children receiving care at the MCH Clinics during fiscal year 2009. This will be re-evaluated during fiscal years 2010 and 2011 to determine the need or effectiveness of this test as to date all tests were reported negative.
Metabolic / genetic screening for inheritable disorders was expanded to 48 conditions using mass spectrometry. Transition of newborn screening to both hospitals was completed in August 2009. Perkin Elmer Genetics Laboratory continued to provide screening. Follow-up of positive results remain the responsibility of DOH and the MCH & CSHCN Program. Discussion under NPM #1.
Collaboration continues with the VI Immunization Program. The goal of the Immunization Program is to ensure that 95 percent or more of all children living in the Virgin Islands up to age 6 are fully immunized in accordance with the Advisory Committee on Immunization Practices (ACIP) recommendations. There are three immunization clinics that administer shots and provide counseling activities on the various types of vaccines administered. The Vaccines for Children (VFC) Program provides vaccines at no cost to children from birth to 18 years who are under-insured or have no insurance, and are covered by Medicaid. Discussion under NPM #7

Direct Care: The program assures access to preventive and primary health services for infants, young children and adolescents, including allied health and other health related services. Specialty clinics provide pediatric specialty services that are generally unavailable or inaccessible to low-income, uninsured or underinsured families. Cardiology clinics provide assessment and evaluation of heart disease and provide medical treatment and management. Hematology clinics provide evaluations and family education for children with sickle cell disease, hemoglobinopathies, and follow-up for other hematological disorders such as leukemia. Orthopedic clinics provide specialized exams, diagnostic procedures, and intervention recommendations for conditions such as scoliosis, and other orthopedic conditions. Diagnosis, treatment and follow-up care for the full range of neurological disorders in children, including comprehensive evaluation and assessment for multiple neurological and/or complex neurological conditions are provided. Comprehensive services for children with known genetic syndromes, including comorbid neurodevelopmental/neurocognitive diagnosis, treatment, and ongoing care are also available.

Specialty services are offered to all children in the territory regardless of ability or inability to pay. There is a perpetual shortage of pediatric specialties in the Virgin Islands. The specialists that we have on island serve primarily the adult population. It is not cost effective to send children to Puerto Rico to have general screening for orthopedic concerns, evaluations of cardiac murmurs or neurologic issues, therefore these sub-specialty pediatricians provide regular valuable services in the territory.
The majority of children referred to the Orthopedist are for evaluation of genu varum, genu valgum and scoliosis. Several of those children have mild cases that should resolve spontaneously; however, there are several that have required special shoes or other devices and need follow up within a few months. It would not be cost efficient to send those children back and forth to Puerto Rico for these types of evaluations. Finances must be reserved for those individuals who require surgical intervention for problems like progressive scoliosis, Blount's Disease, slipped femoral epiphysis, aseptic hip necrosis or even clubbed feet. The post surgical follow up of these patients is done at MCH clinic and not in Puerto Rico.
The ability to have a Pediatric Neurologist available for early screening and evaluation for suspected developmental delay has been beneficial in getting many children into early intervention programs, thus providing good outcomes as compared to the past, where these children diagnosed with a developmental delay in Head Start, hence requiring more intensive therapy. With the Neurologist coming to MCH, financial resources are available to help families perform the genetic and metabolic testing required to make a diagnosis for some of the developmental delays noted in these children. With the increased number of premature infants surviving with histories of intraventricular hemorrhages and other usual complications of extreme prematurity, more children are being referred to the Neurologist for evaluation -- all of whom cannot be sent to Puerto Rico. Just as the national numbers for Autism have increased, so have the numbers increased locally requiring neurologic evaluation. The Neurologist collaborates with the pediatricians and the allied health services to create a plan of action for these children. With the formation of the Autistic Spectrum group (Virgin Islands Autism Network-VIAN) , a plan of action should be formalized over the next year.

Enabling Services: Translation services at clinics are available through bilingual staff for Hispanic-Spanish speaking clients and French-dialects from the eastern Caribbean islands. Transportation services are not routinely offered but can be arranged with the administrative office. Off-island air transportation may be provided based on need and availability of funds. Home visitation is conducted on a priority basis for high-risk populations. Nutrition services are offered by Women, Infant and Children's Program (WIC).
There was a noticeable, though not documented, increase in the number of uninsured children of undocumented families who have not met the residency or other legal requirements to apply for medical assistance, or who would not otherwise receive health care, seeking health care and sub-specialty health care through the program. Provision and delivery of these services enabled high risk populations to establish relationships with the health care system.
By partnering with many of the community based organizations such as VI Perinatal Inc., VI PUSH, and VI FIND -- all organizations that provide support services, training information, and resources to parents, health care providers, and schools, we have been able to enhance our outreach efforts to educate our clients as well as provide family support services. Our continuous efforts to educate our clients within the clinic setting has improved as evidence-based medicine guidelines are easily accessible via internet linkage to the AAP website and CDC website.
An awareness campaign about Fetal Alcohol Syndrome (FAS) was launched throughout our community by placing posters/brochures with information about FAS in our prenatal clinics, Pediatric Clinics and within the Family Planning Clinics. Within the prenatal clinics, screening efforts have increased by assessing and documenting the amount of alcohol that each pregnant female consumes to identify these pregnancies as high risk pregnancies for FAS. This practice of documenting alcohol use during pregnancy is also done by the Pediatrician who is present at the delivery of the infant as a backup measure to identify high pregnancies for FAS.
As a member of the Early Childhood Education and Care Committee, MCH has partnered with other agencies that are a part of the Committee to devise methods to incorporate education and awareness of FAS as a part of the early childhood workers' training in order to increase early

identification of children with FAS.

Infrastructure building services: The program continued activities directed at assuring the availability of the infrastructure necessary to delivery of services to the maternal/child population and to increase access to quality health care for families who lack sufficient financial resources to meet the costs of medical care. Access to staff development activities, training and technical assistance to assure continuous quality of care was provided. Improvement in data collection activities for monitoring and evaluation of services to this population was undertaken during this fiscal year. Challenges remain with a lack of adequate data linkages and child health information systems to support program activities including data collection and analysis. Program policy and procedures manual is revised to address the need for standards and guidelines for service provision, data collection, training and quality assurance / improvement.
Planning activities directed at addressing infrastructure and development of a comprehensive continuous quality improvement plan to assist in building organizational development and system capacity were initiated in FY 2008 and resulted in the formation and development of a Continuous Quality Improvement (CQI) Team within the MCH Program structure. The CQI Team continues to assist with the development and implementation of strategic plans to improve coordination and integration of MCH services; assist MCH leadership and management in the development and implementation of a comprehensive CQI plan to ensure ongoing assessment, program planning, evaluation processes and practice; and improve ability to develop and conduct 5-year needs assessment. Technical Assistance from MCHB was awarded for the crucial CQI activities.

In the area of workforce development, a two year program - Leadership Education and Developmental Disabilities (LEADD, was started in September 2007. The program was presented by the Westchester Institute for Human Development and the School of Public Health, New York Medical College in partnership with the VI University Center for Excellence in Developmental Disabilities (VICEDD) at the University of the Virgin Islands (UVI); and funded by a grant from MCHB. LEADD broadens the opportunities for continuing education and leadership development available to MCH, health and other professionals in the VI, especially as related to children with developmental disabilities and their families. The program uses blended learning distance education methods which combines live classes, computerized virtual classroom instruction, online discussion and self-study. Individuals registered in this four-semester, two-year program graduated in December 2009 and received academic credits offered by the School of Public Health, New York Medical College. Courses were taught by faculty from the Westchester Institute of Child Development and included major topics of current interest, introduction to the public health perspective, understanding and addressing health disparities and cultural competence, family-centered care, distinctive concerns of the Caribbean and Virgin Islands, leadership and genetics and other specific topics.

C. Organizational Structure

The MCH & CSHCN Program is a unit within the Department of Health, one of 14 government departments. The Department of Health is headed by the Commissioner of Health. The Department of Health was reorganized in February 2010. The executive staff consists of the Commissioner of Health, Administrator for Policy and Program Planning, Deputy Commissioners for Divisions of Public Health Services, Fiscal Affairs, Administrative Services and Management and Health Promotion and Disease Prevention.

The Department of Health's mission is to provide quality health care, regulate, monitor and enforce health standards to protect the public's health. This is achieved by open communication with the public, informing them of health care options, thus serving as a catalyst to assist them in making educated choices on receiving the highest quality of health care. The agency is committed to building a sound policy and program infrastructure that reflects the twenty-first century. The Department is the sole state agency responsible for coordinating and providing a

focal point for territory wide public health efforts on behalf of Virgin Islanders and visitors to the territory.
As mandated by Virgin Islands Code, Titles 3 and 19, the Department of Health (DOH) has direct responsibility for conducting programs of preventive medicine. The agency is committed to building a sound policy and program infrastructure through employing providers and administrators from every aspect of health care.

The MCH & CSHCN Program is operated as a single organizational unit and serves as both local and state agency. This single State agency is authorized to administer Title V funds and is responsible for both Maternal and Child Health and Special Needs Children Services. The Administrative Unit is composed of the Director for MCH & CSHCN, Assistant Director, Program Administrator, Territorial Financial Manager (this position was vacated in May 2010. Recruitment is underway), and Office Manager.

The MCH & CSHCN Program is guided by an advisory council, which is charged with the responsibility of advising the Administrative Unit of the MCH & CSHCN Program. The Advisory Council assists in developing goals and objectives, long range program planning, identifying service gaps, locating resources, and monitoring the quality of services provided. Members of the Council include representatives from: Family Planning, Departments of Education, Human Services and Justice, Infants and Toddlers, 330-funded health centers, parents and guardians of children with special health care needs, child care providers, hospitals and faith and community-based organizations. The MCH Director, Assistant Director and Program Administrator are ex-officio members. The Advisory Council was revitalized in 2003 with the election of a dynamic chairperson who played a major leadership role in revision of the By-Laws of the Council. Several committees were formed to address issues and challenges within the program including program evaluation, quality improvement, public awareness and family participation. Members of the council also served on the ad hoc committee for the five-year needs assessment. Council members are instrumental in review of the Block Grant narrative and provided valuable input. Due to limited resources, the Council was unable to have a joint inter-island meeting this past fiscal year. However, individual members have reviewed and provided input on the draft 2010 needs assessment instrument and approved the Adolescent Health questionnaire in its current form. Members also volunteered to form a core group for review of the Block Grant application and as facilitators for proposed focus groups for both surveys.

Hospitals: The two public hospitals are under the management of a Territorial Board and two District Boards established under Bill No. 20-0366.
The Schneider Regional Medical Center (SRMC) is the umbrella entity for three facilities under one health care system on St. Thomas.
The Roy Lester Schneider Hospital (RLSH) is a 169-bed acute care facility located on St. Thomas. Since 1982, it has served the residents of St. Thomas and nearby St. John, St. Croix residents who have required its services, as well as 1.2 million visitors who arrive by air and cruise ships each year. Meeting the health care needs of its community has required constant expansion of medical services, and recruitment of highly qualified and board certified medical professionals. The hospital is a popular provider of choice for the USVI community, and, given the services now offered, it is the convenient option for many patients from throughout the Eastern Caribbean region who are referred here for treatment.
As a Joint Commission accredited facility, RLSH is committed to maintaining a superior standard of performance in all areas. Staff education and training are continuous, and an organization-wide focus on coordinated customer service is maintained.

Myrah Keating Smith Health Center: Located on St. John, this center serves as an ambulatory facility. In 1999, management of this facility was turned over to the Roy L. Schneider Hospital and the Hospital's Board. The Center is the island of St. John's only 24-hour outpatient health center that offers primary and preventative care health services. This facility also provides services in women's health, high-risk OB/GYN, well woman examinations including PAP smears, complete pelvic exams, pre and post-natal care. well baby care, immunizations, minor surgery,

and community education programs. The facility is staffed to provide many other services, including adult medicine, radiology, opthalmology, laboratory, and nutrition counseling.

The Charlotte Kimelman Cancer Institute is a patient centered, 24,000 square foot state-of-the-art, comprehensive cancer center which provides a range of comprehensive out-patient diagnostic and treatment services, combining clinical, research, educational, and patient support under one roof. Oncology services include radiation therapy, chemotherapy, and pediatric oncology. CKCI's diagnostic capabilities include Interventional Radiology, Nuclear Medicine, CT Scan, Mammography, and Diagnostic Pathology. CKCI's resources are made available for community use, as well, as part of the strategy to educate the community, and to promote greater public awareness of cancer prevention and treatment methods.

The Governor Juan F. Luis Hospital and Medical Center, located on St. Croix US. Virgin Islands is a 188 bed facility. As the only full service hospital, it offers acute emergency and ambulatory care in a wide range of services including, general and specialty medicine, surgery, pediatrics, obstetrics, gynecology, psychiatry, physical medicine, hemodialysis and others. The facility is accredited by the joint commission on the accreditation of health care organizations (JCAHO), certified by the Center for Medicare and Medicaid (CMS), a member of good standing with the National Association of Public Hospitals and American Hospitals Association. The hospital pharmacy and blood bank are licensed by the Drug Enforcement Agency and the Pathology and the Clinical lab are also certified by JCAHO.

330-Funded Community Health Centers: An affiliate agreement was signed by the Governor of the Virgin Islands, which placed the governance of the health centers under the authority of governing boards. The health centers are incorporated as not-for-profit entities. Both 330 centers are private corporations independent of the Department of Health.
The Frederiksted Health Center, (FHC), serves approximately 25,000 (USVI 2000 Census tract) on the western side of St. Croix. Adjacent to FHC is the Ingeborg Nesbitt Urgent Care Center (INC), which provides walk-in services to patients of all ages. Critical patients are transferred to the Governor Juan F. Luis Hospital and Medical Center. Laboratory services and pharmaceutical services are provided on site. FHC services include: Family Practice, Family Planning, Prenatal, Pediatrics, Women's Health, Social Services, and Immunizations.
The facility is partially federally funded under a Section 330 Rural Health Initiative and Ryan White Title III - Early Intervention Services Grant Program through the U.S. Public Health Service and partially locally funded through the Virgin Islands Government to provide accessible, quality , primary health care for the people of Frederiksted and the identified surrounding residential areas. The facility serves Medicaid (MAP), Medicare, third party Insurance, self pay and indigent clients.

The St. Thomas East End Medical Center (STEEMC), on St. Thomas, serves the medically under-served population of approximately 24,000 on the heavily populated eastern end of the island.
STEEMCC's mission is to increase access to comprehensive primary and preventive health care and to improve the health status of underserved and vulnerable populations. STEEMCC's goals are to eliminate barriers and health disparities, assure access to quality care, and improve the health care infrastructure. Primary and preventive health care strives to address the current disparities in health care by providing accessible high quality, appropriate, affordable, family oriented, comprehensive primary and preventive health care services to individuals, families and the community at large.
STEEMCC provides a cadre of services for its patients but its main focus is on providing primary and preventive health care. These services include, but are not limited to, medical primary care, walk in services, oral health, psychiatric referrals, HIV testing and counseling, pediatrics and prenatal care, hypertension, cholesterol and diabetes screening and counseling, family planning services, breast and cervical cancer screening and prostate testing.
Ob-Gyn care includes gynecological care, prenatal care, antepartum fetal assessment, referral for ultrasounds, genetic counseling and testing, and postpartum care. Oral health care services

include preventive, restorative, and emergency based on availability of providers.

Community Health Clinics: The Community Health Centers conduct comprehensive programs of preventive and curative medical care by means of direct clinical services. The St. Thomas Community Health Clinic is located at the Roy Lester Schneider Community Hospital. This clinic provides prenatal, gynecology, family planning services, and pediatric services. On St. Croix, the Community Health Clinic is located at the Charles Harwood Complex. Services include eye clinics, diabetic clinic and primary care for adults. This activity center screens, diagnoses and treats patients with medical problems such as diabetes, hypertension, cardiovascular disease and arthritis. Sub-specialty clinics which provide services in neurology, urology, podiatry, orthopedics, minor surgery, wound management and allergic/dermatologic disease are conducted.

Emergency Medical Services: The Emergency Medical Services (EMS) is the agency charged with the provision of pre-hospital emergency medical care. Inter-island patient transfer services between St. Croix - St. Thomas and Puerto Rico or the continental United States are privately arranged. Patient transfer services between St. John's Myrah Keating Smith Clinic and St. Thomas Roy Schneider Regional Medical Center are via EMS Ambulance Boat. This agency is responsible for management of the ambulance system, and participates in the delivery of emergency care within the hospital emergency department and the Health Department clinics. EMS provides training for all health care providers, Physicians, Nurses, EMTs and Paramedics. Their training including Pediatric Advanced Life Support (PALS), Advanced Cardiac Life Support (ACLS), Emergency Vehicles Operators Course (EVOC), and Basic Cardiac Life Support courses for the public. The Virgin Islands Emergency Medical Service is a franchise of the American Heart Association.
The Division of EMS has established a training facility in the St. Thomas-St.John District. The VI-EMS was awarded a $345, 000.00 Grant for the period March 2006 -- February 2009. This grant specifically seeks to promote the development of children specific EMS policies and procedure in the territory.
Funding from this grant has been used to: support an EMSC Advisory Committee; attend mandatory grantee meetings; provide pediatric and trauma education for EMS personnel; finance the development and printing of EMS Policy Manuals and purchase equipment to assist with proposed plans to transition the division from paper to electronic records. VI-EMS was able acquire a customized Mass Casualty Management System Trailer. This Mass Casualty Incident Trailer will be used for any type of incident whether manmade or natural disasters. The funding source was through the Office of Homeland Security.

D. Other MCH Capacity

III - D. OTHER CAPACITY
Role of the Parents: Parents play a vital role in the program planning and evaluation, quantitatively, and qualitatively. Parents are involved in preliminary planning and implementation of each program. There are parent representatives on the MCH Advisory Council and the V.I. Interagency Coordinating Council. Here to Understand & Give Support (HUGS-VI) is a Parent Support Group for parents and caregivers of individuals with Special Needs. HUGS mission is to bring families and partners together to empower those with disabilities through learning, sharing, recreation and social events. HUGS-VI offers training programs about Special Education rights, and other programs that encourage those with disabilities to maximize their living potential.

Health Planning: The Bureau of Health Planning is charged with the regulatory responsibility of administering the Certificate of Need (CON) program established by Title XIX of the Virgin Islands Code. The Bureau's mission is to guide the establishment of health facilities and health services by administering a CON program that will best serve the needs of Virgin Islands residents. The fundamental premise of the Certificate of Need (CON) program is to restrain the ever-increasing health care costs; prevent the unnecessary duplication of health care facilities; and finally to achieve equal access to quality health care at a reasonable cost.

Office of Primary Health Care: The mission of the Office of Primary Health Care (OPHC) is to increase access to primary health care for all US Virgin Islands' residents, regardless of ability to pay.
It's vision is to educate the population by increasing health consciousness in the Virgin Islands relative to reducing health disparities, increasing access to health care, and developing strong ties with health partners in addressing public health education opportunities.

The OPHC's goal is to address healthcare workforce shortages in the US Virgin Islands through collaborations with national and local healthcare decision-makers, stakeholders, and professionals.
Primary objectives of the OPHC are:
-To facilitate Health Professional Shortage Area (HPSA) and National Health Service Corps (NHSC) site designations for all qualified health centers and clinics.
-To coordinate the NHSC program, which includes, providing assistance with recruitment and retention of healthcare professionals and serving as a NHSC ambassador to promote and fill healthcare provider vacancies in the US Virgin Islands.
The Virgin Islands Primary Care Office (VI PCO) is federally funded by the US Department of Health and Human Services, Health Resources and Services Administration (HRSA), Bureau of Primary Health Care (BHPC), Bureau of Clinician Recruitment and Services, and Bureau of Health Professions (BHPr).

Office of Vital Records and Statistics (VRS): Vital Records and Statistics collect, analyzes, and disseminates vital events data in the territory. The program works with the courts, healthcare facilities, the University of the Virgin Islands and other agencies involved in births, deaths, marriages and divorces. Its mission is to ensure the registration of live births, deaths, and other vital statistics in the territory.
As Vital Records and Statistics is the key agency in the Department of Health for correlating health related statistics, its vision is to create an environment conducive to the delivery of information necessary for the planning and delivery of quality health care.
Vital Records and Statistics is committed to maintaining accurate health data and vital statistics of the US Virgin Islands to divisions within the Department of Health, the Virgin Islands community and the National Center for Health Statistics.
This office generates the health statistics, leading causes of death and maintains a cancer registry for the Virgin Islands. Due to technical and managerial personnel shortages, this office remains limited in its capacity to analyze data.

Health Information Technology (HIT): This office is responsible for evaluating and recommending hardware and software for the various programs/divisions. Responsibilities include: installation, maintenance, training and ongoing support of all computer and communication systems. Additional functions include research and development of new applications for technological advancements, which can reduce costs while improving efficiency. The goal of HIT is to automate all programs/divisions within a comprehensive network for electronic data sharing and telephone interconnects via a technologically advanced communication network. Internet access, E-Mail, data sharing, and an Integrated Health Information System for all clinics are provided through this network.

Family Planning Program: Family Planning is authorized by Section X of the Social Security Act. The V.I. Family Planning Program was initiated in 1979 to support the provision of voluntary services primarily to low income persons. It serves as a point of entry into the public health system to women at risk for unintended pregnancy, sexually transmitted diseases including HIV/AIDS, and in need of primary care services. Outreach services intended to encourage healthy behaviors among Virgin Islands families especially adolescents is also a vital component of this program.
The mission of the Family Planning Program is: "To promote optimal health in our community, in the full understanding of the culture, habits and needs of our community, by assisting and

counseling individuals, mainly women of childbearing age, and families to achieve the goals they have set for family size; by promoting healthy sexual attitudes and behavior, and by improving adolescents understanding and attitudes about human sexuality and contraception". The program provides: medical evaluations, human sexuality and contraceptive counseling, infertility management, genetic counseling, and social, nutrition, and health education referrals. The Family Planning Program's accomplishments are related to its mission to provide affordable, culturally sensitive educational, counseling and comprehensive medical and social services necessary to enable individuals, mainly women of childbearing age, to freely determine the number and spacing of their children, help reduce maternal and infant mortality and promote the health of mothers and children

VIFPP seeks to ensure efficient and high quality reproductive health care services including family planning as well as the related preventive and medical treatment that will improve the overall health of individuals. It facilitates access to health information to encourage healthy responsible behavior among at risk youth's age 10-21 years. VIFPP is a forerunner in the encouragement and empowerment of families through proactive involvement in healthy behavior and disease prevention. The program directly impacts more than 5,000 individuals while indirectly impacting 25,000 children, youth, parents, and community residents in the United States Virgin Islands.

Virgin Islands Perinatal Incorporated (VIPI): VIPI was recognized as a tax-exempt 501(c) (3) in 2003. VIPI is a model for consumer involvement. The "Promoting Health Families Initiative" and "Healthy Families…Healthy Babies Initiative" provide community-based health education, outreach services and case management for high-risk pregnant women, diabetics and hypertensive individuals and their families. The main focus of these initiatives are to decrease the rate of pre-term births, diabetes and hypertension, and promote awareness for breast, cervical, prostate and colorectal cancer. This is a community driven project to promote healthier families in the VI with the outcome of a stronger and healthier community. The target population is low-income, uninsured/ underinsured and underserved families. Family Outreach Educators, Care Managers and Prevention Specialists conduct activities to ensure that enrolled clients have access to health care services in a medical home. VIPI instituted the Perinatal Morbidity & Mortality Review Committee (PMMRC) based on the National Fetal & Infant Mortality Review (NFIMR) model to determine the common clinical indicators leading to preterm births and fetal deaths. PMMRC activities have progressed over the past fiscal and calendar years. Data collection and audits of medical charts at Juan F. Luis Hospital on St. Croix was completed and a report summarizing the audit findings was completed and circulated among local healthcare stakeholders. As of January 2010 data collection from medical records at Schneider Regional Medical Center on St. Thomas was underway. This will be completed by July 2010 followed by the finalization of a Territorial Perinatal Morbidity & Mortality Review. In December of 2009, VIPI applied for a federal grant to publish the findings of the review and to host a conference locally to outline these findings and determine the common clinical indicators leading to preterm births and fetal deaths.

The Healthy Families... Healthy Babies Initiative expanded to the St. Thomas-St. John District in FY 2006 and currently provides services at the VIDOH Community Health Clinic site and the St. Thomas East End Medical Center to include Spanish medical interpretation. VIPI continues to provide services to low-income, uninsured, under-insured high risk pregnant women. 187 women and their families were served since the program's inception on St. Thomas. 71 were served on St. Croix from October 2008 to December 2009.

Due to the rising cost of health care and the growing undocumented population in the territory VIPI established a workgroup to evaluate local capacity, create a local border health frame-work and conduct efforts for policy development. Efforts to collect data & quantify trends of non-citizens usage of local public health resources were made. It was proposed that available Border Health resources be identified to assist in addressing the financial and systemic burden placed on the territorial resources. Discussions focused on the territory's ability to continuously and effectively respond to the health care needs of non-citizens. As of June 2009, VIPI Border Health Coordinator met with the Virgin Islands Delegate to Congress Donna M. Christensen to highlight

this growing trend and obtain suggestions on federal policy with regards to the territory gaining border health certification. With invaluable guidance from the Delegate to Congress, VIPI and its major stakeholder, Schneider Regional Medical Center met with representatives from the Office of Insular Affairs (OIA). This agency oversees administration of several United States possessions/territories (Marshall Islands, Guam, USVI, etc.) and administrative responsibility for coordinating federal policy in the territories and oversight of federal programs and funds. The meeting was productive and provided valuable input into the workgroups efforts to purse designation as a Border Territory.

E. State Agency Coordination

The MCH & CSHCN Unit plays a leadership role in developing a comprehensive system of service. Agency and community resources include Human Services, Developmental and Disabilities Council, Department of Justice (Office for Paternity & Child Support), Department of Education, Special Education / Early Childhood Program, Head Start Program, and Disabilities and Rehabilitation Services. The V.I. Advocacy Agency, Inc., and Legal Services provide an effective voice for persons with disabilities. Representatives of these agencies serve on the MCH & CSHCN Advisory Council, V.I. Interagency Coordinating Council, and the V.I. Alliance for Primary Care, and participate in planning and evaluating services for children with special health care needs.

Several government agencies, programs, foundations or community based organizations provide services to this vulnerable population comprised of women in their reproductive age, children and adolescents especially those with special health care needs. Appropriate coordination among all concerned agencies is vital in order to reduce duplication of effort and fragmentation of services, and to be more efficient in the use of limited resources. The VIDOH has established formal and informal relationships with other public agencies, academic institutions, and health care facilities. These relationships enhance the availability of comprehensive services for the MCH population. There are also memorandums of understanding among agencies and programs, which enhance coordination of services.

Infant and Toddlers Program: The Early Intervention program for Infants and Toddlers with Disabilities was established under PL 99-457. Through executive order of the Governor, the Virgin Islands Department of Health (VIDOH), as the lead agency ensures that the Infants and Toddlers Program (ITP) maintains a territory-wide, coordinated, multidisciplinary, interagency system of early intervention services for infants and toddlers with disabilities and their families. In accordance with CFR 34 303.124 early intervention services provided through ITP supplement, but do not supplant, state and local funds expended for children eligible under this part and their families. The overall goal of the program is to enhance the capacity of families to meet the special needs of their children.

ITP supplements the MCH & CSHCN Program, when public or private resources are otherwise unavailable, providing early intervention services such as: service coordination, physical and occupational therapy, speech and language pathology, vision therapy, special instruction, and family training.

ITP's collaborative efforts with and close physical proximity to the MCH & CSHCN Program are especially effective via Child Find activities. The program contributes its success to its continued efforts to maintain early referrals to the program. Private physicians, hospitals, other public clinics, and child care centers are visited and Part C program information shared and disseminated. The program issues a written notice on receipt of the referral to the primary referral source and provides feedback that indicates if the child is eligible. Early intervention services are rendered in the Part C of IDEA eligible child's natural environment and are provided during the early weekday evenings and on Saturdays, in addition to the work week times. Other collaborations are being initiated to increase early identification and referrals, and maintain rapport with primary referral sources, such as hospitals, clinics and private physicians. Representatives from the program periodically visit with private pediatricians in their offices thanking them for referrals and presenting a clear and concise message of the benefits.

ITP will continue current efforts to maintain a comprehensive child find system and continue monitoring referral sources and current outreach efforts.

V.I. Interagency Coordinating Council: The V.I. Interagency Coordinating Council (VIICC) is charged with the task of advising and assisting the Department of Health in the implementation of the Individuals with Disabilities Education Act. The VIICC includes representatives of state public agencies, such as the Department of Health, MCH & CSHCN, Department of Human Services, Department of Education, Special Education/Early Childhood Education, University of the Virgin Islands, public and private providers, advocacy agencies, parents of children with disabilities, and the V.I. Legislature. An Interagency Memorandum of Understanding with the Departments of Health, Human Services, and Education coordinates the early intervention services for children under three years. This agreement is to be revisited to include children 0 -- 5 years.

Early Childhood Advisory Committee: Early Childhood Advisory Committee (ECAC): An interaency advisory committee established by the Office of the Governor to fulfill the mandates in the Improving Head Start for School Readiness Act to improve the lives of young children and their families. The purpose is to develop an agenda for improvements in child care and early childhood education that improves school readiness.

Mental Health Services: Pursuant to Title III, Section 418, of the Virgin Islands Code the Department of Health is designated as the single State agency for mental health, alcoholism and drug dependency. The Division of Mental Health, Alcoholism, and Drug Dependency Services ("DMHADDS") is the agency charged with establishing and administering programs designed to offer prevention and treatment intervention services in the areas of Substance Abuse Prevention, Substance Abuse treatment, Mental Health, and Residential Services. Services are offered territorially at four (4) out-patients clinic sites and one residential facility.
Data reported for FY 2009 shows that this activity center provided services to 110 children ages 1 -- 17. These services included individual, family and group therapy; monitoring of medication and psychiatric evaluations.

V.I. University Center for Excellence in Developmental Disabilities (VIUCEDD): Established in October 1994 the Center was funded by the US Department of Health and Human Services, Administration on Developmental Disabilities and the US Department of Education, Office of National Institute on Disability and Rehabilitation Research.
The VIUCEDD mission is to enhance the quality of life for individuals with disabilities and their families and to provide them with tools necessary for independence, productivity and full inclusion into community life. This is accomplished by providing a continuum of educational opportunities through which the student in Inclusive Early Childhood Education may earn a Certificate, an Associate of Arts Degree, and a Bachelor of Arts Degree.
The primary goals of VIUCEDD are to: demonstrate exemplary approaches in clinical, educational and community settings; provide technical assistance to community and educational entities; disseminate information related to the implementation of evidence based practices; ensure participation of persons with disabilities and their families in the design and implementation of all VIUCEDD activities ; collaborate and coordinate activities for families with children with disabilities that promote their independence, self advocacy and integration into the community; provide training on the laws that protects the rights of persons with disabilities and their families; and provide training to schools regarding the school wide issues on positive behavior supports and inclusive practices.
The unique nature of working with young children implies that professionals develop the skills necessary for working with and collaborating effectively with families and other professionals. A broad knowledge of development and learning from birth through age eight is necessary for educators to provide appropriate curriculum and assessment approaches. The fact that not all children develop at the same rate and children with developmental delays and disabilities are included in typical early childhood classes requires that professionals have knowledge of an even wider range of development and learning. In response to this challenge, the Inclusive Early Childhood Education (IECE) Program at the University of the Virgin Islands was created. The

program is designed to ensure that students learn about the variability of young children and the adaptations and modifications that can be made to ensure typical development and learning experiences for all children. The program stresses the importance of natural environments, play support, and the integration of developmental and learning experiences into the curriculum. Students are trained to assume the primary role of facilitators of child development and learning and parent-child relationships.
VIUCEDD also offers American Sign Language courses during the fall and Spring semesters, and technical assistance to community groups serving individuals with disabilities.
An Assistive Technology degree is offered as an option within the Masters of Education program at UVI. Courses are taught by visiting faculty from the Graduate School of Health Sciences at New York Medical College and the Westchester Institute for Human Development University Affiliated Program.
The VI Assistive Technology Foundation (VIATF) offers persons with disabilities access to low-interest bank loans to purchase assistive technology (AT) devices and services. Under VIATF, the cost of the borrowed money is significantly reduced. Any Virgin Islands resident who has a disability and/or any family member or guardian of a person with a disability can apply for the loan. The applicant must satisfy the standard bank loan requirement which is mainly the ability to repay the loan.
Vocational Rehabilitation Program: The Vocational Rehabilitation Program is authorized by the Rehabilitation Act of 1973, Public Law 93-112 and its amendments. The program is administered by the Department of Human Services. The program offers services to eligible individuals with disabilities in preparation for competitive employment including: supportive employment through Work-Able, a non-profit placement agency; independent living services; provision of a vending stand program for visually impaired individuals; and in-service training programs for staff development.
Summary of Service Delivery: Disabilities & Rehabilitation Services
Basic Grant: Under this grant, vocational rehabilitation services conducts assessments for determining eligibility, provide counseling, guidance, and referral, physical and mental restoration services, coordinates vocational and college activities and on-the-job training and transportation for individuals with disabilities. Additionally, it coordinates and funds support services which include: interpreter services for individuals who are deaf, reader services for individuals who are blind, services to assist students with disabilities transition from school to work, personal assistance services, rehabilitative technical services and devices, supported employment and job placement services. In fiscal year 2009, the program provided services to 74 persons under 19 years of age, and 44 persons 20 years or older. Data on gender, race and ethnicity is not available.
(Source: DHS Annual Report FY 2009)

Developmental Disabilities: The Developmental Disabilities Program is authorized under Public Law 106-402, the Developmental Disabilities Assistance and Bill of Rights Act of 2000. The purpose of this act is to improve service systems for individuals with developmental disabilities; and to assure that individuals with developmental disabilities and their families participate in the design of and have access to needed community services, individualized supports, and other forms of assistance that promote self-determination, independence, productivity, and integration and inclusion in all facets of community life. In the Virgin Islands, the Department of Human Services administers the Developmental Disabilities Program through its developmental services component. The developmental services component provides grants to public and private non-profit organizations that provide services such as legal advocacy, employment, training, and special transportation. The Developmental Disabilities Council advises the Department of Human Services in the performance of these functions. The Title V MCH & CSHCN Program Director is appointed to the Council by the Governor of the Virgin Islands.

Women, Infants and Children Program: The WIC Program is administered by the United States Department of Agriculture, Food and Nutrition Service, through Section 17 of Child Nutrition Act of 1966, as amended. The program serves as an adjunct to good health care during critical times of growth and development, in order to prevent the occurrence of health problems, including drug

and other harmful substance abuse, and to improve the health status of women, infants and children. The program provides supplemental foods and nutrition education.
The VI WIC Program is 100% federally funded and is administered by the Department of Health. The purpose of WIC is to serve as an adjunct to preventative health care services during critical times of growth and development, in order to promote and maintain the health and well being of nutritionally at-risk women, infants and young children. Persons eligible for the program include pregnant, breastfeeding and postpartum women, infants and children up to age five who are determined by a health professional to be at nutritional risk and meet income criteria. WIC promotes breastfeeding as the optimal infant feeding choice unless contraindicated.
The VI WIC Program remains dedicated to provide family-centered nutrition education and services to WIC participants/caretakers in order that optimal growth and development of infants and children occur, and to assist in prenatal, postpartum and breastfeeding women making informed health and dietary choices for themselves and their families. An 86% partial breast-feeding rate among WIC post-partum participants was maintained. Exclusive breastfeeding rate is at 3%. See discussion under NPM # 11 & 14.
Nutrition Services within the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) are provided to improve the nutritional status of its target population. These services are provided at no cost to the participant as defined in federal regulations [246.11(a) (1)]. The Virgin Islands WIC Program accordingly, provided nutrition education, supplemental foods, food demonstrations on ways to use WIC foods, and referrals to other health and social services agencies. Nutritionists provided high-risk nutrition education contacts to WIC participants. VI WIC provided nutrition and clinical services to approximately 5,568 participants in FY 2009. See discussion under Performance Measure # 11 & 14.

Office of Child Care & Regulatory Services: The Department of Human Services, Office of Child Care & Regulatory Services, in collaboration with several partner agencies, works to improve the quality of child care in the territory and to ensure that quality child care is accessible to all families in the Virgin Islands. These goals are accomplished by enforcing the minimum standards for the safety and protection of children in child care facilities, in-home care, group homes, summer camps, and after school programs; insuring compliance with these standards, and regulating such conditions in such facilities through a program of licensing. Using a sliding scale, eligibility is determined and subsidized child care is provided for the territory's eligible low income families through the voucher reimbursement program. This program serves infants to after school children from birth to age 13. Additionally, child care providers receive technical assistance and support to enhance and promote high quality early care and education in the territory.

Community Foundation of the Virgin Islands (CFVI): CFVI was created to serve both donors and nonprofit organizations of the Virgin Islands that want to ensure the highest quality of life for both present and future generations. Its primary goal is to build a collection of permanent funds, which will be used to enhance the educational, physical, social, cultural and environmental well-being of the children, youth, and families of the Virgin Islands. CFVI funds several programs and initiatives including Voices for Virgin Islands Children whose mission is to promote the well-being of and empower children, youth and families in the US Virgin Islands through research, media outreach, public education and legislative advocacy. In addition, it seeks to involve the community as non-partisan, nonprofit advocates for children's needs and rights.
The KIDS COUNT USVI Data Book provides information on child well-being in the U.S. Virgin Islands. Its purpose is to promote dialogue on children's issues, and to stimulate community response to improve the health, safety and economic status of VI children, from birth to age eighteen. USVI KIDS COUNT is part of a national initiative, sponsored by the Annie E. Casey Foundation, to create a detailed community-by-community picture of the condition of children nationwide. There are now KIDS COUNT projects in all fifty states, the District of Columbia, Puerto Rico, and the US Virgin Islands. Since 2000, the KIDS COUNT USVI Data Book has been compiled and published each year by the Community Foundation of the Virgin Islands (CFVI), serving the needs of the territory's children, youth, and families. Another initiative, The Family Connection (TFC) has built a cutting edge resource library with more than 250 professional titles on early literacy, curriculum, child psychology, and the business management

of child care centers. Additionally, TFC center offers a lending library with more than 1,000 developmentally appropriate toys and children's books. Over 150 parents, child care providers, teachers and university students are regular visitors to the TFC Center. TFC is the leader in early child care professional development, providing early childhood social and emotional workshops as well as early literacy workshops in the USVI territory. TFC also frequently reaches out to community groups to provide training by request. The TFC Center has become an important space for the early childhood community to gather and share ideas on raising the standard for high-quality care in the U.S. Virgin Islands. TFC has expanded its services with weekend and evening hours, an increase in staff, and a new center in development on St. Croix. TFC continues to reach out to the early childhood community by offering impact grants of up to $5,000 for early childhood education initiatives.
The Family Connection (TFC) introduced Born Learning, a public engagement campaign focused on the importance of creating early learning opportunities for young children. The goal of Born Learning is to make lasting community change through building public awareness, education and community action. Born Learning was created by the national United Way, and is endorsed by our local United Way agencies. TFC produced three localized Born Learning radio spots to teach parents how to make every day moments learning moments. TFC staff made guest appearances on radio shows to spread the word and raise awareness about the importance of Born Learning in the community. TFC also made Born Learning presentations and distributed learning materials Territory-wide at professional development and parent orientations. TFC expanded the Born Learning campaign to businesses, private childcare centers, and doctors offices. CFVI opened the first Born Learning Trail in the Territory located at Magens Bay. The trail includes 10 signs designed to assist parents and child care providers with creative ideas on communicating and interacting with their children.

Medicaid Program: The Bureau of Health Insurance and Medical Assistance is the agency within the Department of Health responsible for the administration, planning and coordination of Title XIX (Medicaid), which is a fixed, capped grant, and Title XXI (Child Health Insurance Program or CHIP). The Virgin Islands State Plan for Medical Assistance was approved by the Department of Health and Human Services (formerly Health, Education and Welfare) and has been in operation since 1966. The mission of the Medical Assistance Program is to assure that health care is readily available and accessible to all eligible low income persons and that the care is of high quality, is comprehensive and continuous. To fulfill this mission, the Program must:

- Assure that clients have access to necessary medical care
- Assure that the quality of care meets standards
- Promote appropriate use of services by clients
- Promote appropriate care by service providers
- Assure that the services are purchased in the most cost-effective manner.

Eligibility is based on family income, available resources, and other factors. As the payer of last resort, the MCH & CSHCN Program is fiscally linked to the Medical Assistance Program. The Medical Assistance Program (MAP) functions under a congressionally imposed cap with a ratio of Federal and Local matching of 50/50. Mandatory Medicaid services include inpatient hospital, outpatient hospital, health clinic services, laboratory & x-ray services, Early & Periodic Screening, Diagnosis & Treatment (EPSDT), Family Planning, Nursing Home Services, Physician Services that must be pre-authorized, and Dental services. Optional services (but covered) include: optometrists, eyeglasses, prescribed drugs, air transportation, and respiratory therapy.

Child Health Insurance Program: Title XXI of the Social Security Act was enacted August, 1997 and provides 24 billion dollars over five years to insure millions of American children in families at or below 200% of poverty for children not eligible for Medicaid or other public or private insurance. The Child Health Insurance Program (CHIP) is administered by the Bureau of Health Insurance and Medical Assistance. CHIP, which has been approved by the Centers for Medicare and Medicaid (CMS), allows for payment of unpaid medical bills for Medicaid patients less than 19 years of age. This waiver was allowed by CMS because Congress did not approve enough CHIP monies for the territories that would have allowed them to have a regular Child Health Insurance Program. These limited funds were used to pay already incurred medical bills

for Medicaid children whose federal Medicaid fundfunding were expended by the end of the fiscal year.
Due to the limitations of the statutory cap and inadequate funding levels, VIDOH has been unable to address the health care needs of uninsured children.

F. Health Systems Capacity Indicators

Introduction

The Title V Guidance requires all States and jurisdictions to report annually on selected Health System Capacity Indicators (HSCI) that assess the capacity of the health care system to address the needs of the MCH population. HSCI primarily assess how well state programs such as Medicaid, SCHIP, and CSHCN are meeting the needs of those eligible for such services. They are also used to determine how successful MCH efforts have been in improving early and adequate prenatal care. In addition, they assess Title V programs' ability to access relevant data sources and linkages. Since these HSCI's measure services provided through Medicaid, SCHIP and SSI, it must be noted that allotments to the Virgin Islands are capped and SSI is not available. The current system does not have an adequate data and information structure to obtain valid, reliable data to respond to these indicators. An integrated data system has not been realized. The availability of information based on valid, accurate and measurable data which is an important requirement for the analysis and objective evaluation of the effectiveness of the Title V remains unattainable. Some data is obtained for most of the Health System Capacity Indicators through a variety of sources, but primarily through the DOH Vital Records & Statistics birth and death certificates, DOH STD/HIV Program, hospital admission records, Office for Highway Safety, and VI-EMS.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	214.4	151.9	65.5	68.9	87.8
Numerator	158	112	52	47	51
Denominator	7371	7371	7937	6823	5809
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009

Denominator obtained from 2007 VI Household Survey, UVI Eastern Caribbean Center.
Numerator obtained from both hospitals denoting in-patient admissions with an average length of stay of 1.5days.

Notes - 2008

Denominator obtained from 2006 VI Household Survey, UVI Eastern Caribbean Center.
Numerator obtained from both hospitals denoting in-patient admissions with an average length of stay of 2.5days.

Notes - 2007

Denominator obtained from 2005 VI Household Survey, UVI Eastern Caribbean Center.
Numerator obtained from both hospitals denoting in-patient admissions with an average length of stay of 2.6 days.

Narrative:
Asthma is a common condition among children in the VI. The MCH Program provides direct care and for children with asthma. A plan to provide both individual and family asthma education and management has been implemented. This will assure that all children diagnosed with asthma receive management skills and knowledge to control the disease. The anticipated outcomes are to decrease emergency department visits, increase early sign recognition and decrease activity limitations. Staff physicians and nurses continue to educate families on the importance of nutrition, healthy eating practices and habits, impact of both first and second-hand smoking, avoidance of environmental and household asthma triggers and other allergens, and appropriate management and treatment of early symptoms to avoid complications. Pulse oximeters and aerosol nebulizers are available in both clinic sites for immediate treatment of children with signs of distress. This availability decreases the need for emergency department visits and in-patient admissions.
Asthma remains a significant public health challenge in the territory and an area where methods to collect and analyze data more effectively is critical. The rates for emergency department and inpatient admissions due to asthma at the Juan F. Luis Hospital on St. Croix were reported at 390 ED admissions during FY 2009. Inpatient admissions with a primary diagnosis of asthma were 38 with the average length of stay 1.2 days. At the Roy L. Schneider Hospital on St. Thomas 109 children were admitted with the average length of stay 1.8 days. Neither hospital discharge nor Medicaid paid claims data for hospitalization is available.
It is generally recognized that children with asthma who are unable to gain access to primary care or prescription medications due to uninsured or underinsured status are at a greater risk of needing hospitalization. Therefore, appropriate asthma management in young children is a primary focus of this program with the ultimate goal of decreasing emergency room visits of young children for asthma related complaints, and to improve the lives of those who live with asthma. Pulse oximeters and aerosol nebulizers are available in both clinic sites for immediate treatment of children with signs of distress.
The Title V program will continue to work closely in collaboration with the VI Chapter of the American Lung Association to create a better awareness of asthma; and to provide asthma education to health professionals, school personnel, and other key individuals who offer services to this population. Additionally, an Asthma Care protocol and plan of action for home and school based on NIH National Heart, Lung, and Blood Institute (NHLBI) and New York State Asthma Plan is being developed for implementation by the end of calendar year 2010.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	0.0	12.4	13.9		
Numerator	0	218	247		
Denominator	1676	1760	1772	1844	1755
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009

Data for this measure is not available or collected by the Bureau of Health Insurance and Medical Assistance.

Denominator obtained from NBS database - live birth admissions for calendar year 2009.

Numerator obtained from number of children under 1 year receiving services at the MCH clinics in both districts.

Notes - 2008
Data for this measure is not available or collected by the Bureau of Health Insurance and Medical Assistance.

Notes - 2007
Data for this measure is not available or collected by the Bureau of Health Insurance and Medical Assistance.

Narrative:
The Early Periodic Screening, Diagnostic and Treatment (EPSDT) program provides well-child and comprehensive pediatric care for children and adolescents through age 20. Medicaid data systems in the territory lack the capability to provide specific data relating to periodic screening in this section. This data is not available from the Medicaid program. The MCH & CSHCN Program lacks access to the paid claims files. Screening services are provided to all children accessing care at the MCH Program. CPT and ICD-9 coding for these services was provided to MAP. Paid claims documentation is unavailable from the MAP. The actual number of eligible children is unknown as the MAP data system does not provide this information.
The EPSDT periodicity schedule is used for all children receiving services at both MCH clinic sites. Estimated clinic sites data shows that 40 % of children have Medical Assistance while 52% are uninsured. Due to the stringent requirements for household income many families and children who are eligible for MAP by mainland standards are not certified in VI. The MCH Program supports delivery of preventive health services, such as health screenings and immunizations; refers uninsured infants and children seen in the clinics for determination of Medicaid eligibility; and encourages collaboration between Title V and the Medical Assistance Program to ensure that EPSDT services are provided to all eligible or certified children. Parent education on EPSDT services is not provided to families at the time of certification by the Medical Assistance Program. Therefore, the Title V program has undertaken to train staff both clinical and administrative to provide this information to parents who access the health care system through MCH clinics regarding the preventive and treatment services and supports that are available to them. The status of the MAP program's ability to report paid claims data remains unchanged. Data is not collected or reported from CMS Form 416.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	0.0	0.0	0.0	0.0	0.0
Numerator	0	0	0	0	0
Denominator	1676	1760	1772	1844	1755
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data for this measure is not available or collected by the Bureau of Health Insurance and Medical Assistance.
The Child Health Insurance Program Plan, which has been approved by the Centers for Medicare and Medicaid (CMS), allows for payment of unpaid medical bills for Medicaid patients less than 19 years of age. This waiver was allowed by CMS as Congress did not approve enough CHIP monies for the territories that would have allowed them to have a regular Child Health Insurance Program.
Denominator obtained from the NBS database - number of live birth admissions for calendar year 2009..

Notes - 2008
Data for this measure is not available or collected by the Bureau of Health Insurance and Medical Assistance.
The Child Health Insurance Program Plan, which has been approved by the Centers for Medicare and Medicaid (CMS), allows for payment of unpaid medical bills for Medicaid patients less than 19 years of age. This waiver was allowed by CMS as Congress did not approve enough CHIP monies for the territories that would have allowed them to have a regular Child Health Insurance Program.
Denominator obtained from the number of live birth admissions.

Notes - 2007
Data for this measure is not available or collected by the Bureau of Health Insurance and Medical Assistance.

Narrative:
This HSCI is not applicable to the V.I. due to the Medicaid Cap. The Child Health Insurance Program, CHIP, is administered by the Bureau of Health Insurance and Medical Assistance. The Child Health Insurance Program Plan, which has been approved by the Centers for Medicare and Medicaid (CMS), allows for payment of unpaid medical bills for Medicaid patients less than 19 years of age. This waiver was allowed by CMS as Congress did not approve adequate Child Health Insurance Program (CHIP) monies for the territories that would have allowed a regular Child Health Insurance Program.
Due to the limitations of the statutory cap and inadequate funding levels, VIDOH has been unable to address the health care needs of uninsured children. Limited S-CHIP funds are combined with MAP to provide health care for Medicaid eligible children. Service utilization or eligibility data is not available from the program.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	40.7	44.9	39.9	24.0	
Numerator	686	787	706	442	
Denominator	1686	1752	1771	1844	

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2009
Data not available from Bureau of Health Statistics for this calendar year.

Notes - 2008
Data for CY 2008 obtained from DOH Office for Vital Records & Statistics.

Notes - 2007
Data obtained from Bureau of Health Statistics is incomplete and reflects the first three quarters of CY 2007.

Narrative:
The Office of Health Statistics and Vital Records Registry is unable to provide complete data at the time of this report. Data provided by DOH and FQHC prenatal clinics for calendar year 2009 shows that 44.7% enrolled in prenatal care in the first trimester (n=647 of 1446), with 40.8% in the second and 14.5% in the third. This is provisional data reported by public health clinics and is not indicative of adequacy of prenatal care for the territory.
Several factors continue to influence the program's ability to maintain and/or improve this HSCI. The main factor is the lack of sufficient OB (MD's, CNM's or CNP's) providers to offer the level of service required to ensure early enrollment and adequate visits. Other factors are barriers such as not being able to get appointments until into the second or third trimester, not enough money, inadequate or no health insurance, and lack of transportation. There is also an increase in demands for prenatal services by women who are generally unemployed, under or uninsured, or are working poor who are not eligible for Medical Assistance (MAP) and are considered self-pay. The restriction of MAP guidelines for U.S. citizens or legal residence for more than 5 years also excludes the growing population of undocumented women. This creates difficulty for receiving early and adequate prenatal care due to lack of a payment source, causing many to enter care in the third trimester or not at all. There is also a lack of access, for the reason that some OB-GYN physicians are not accepting new patients on a regular basis or don't accept uninsured patients, or those with Medical Assistance.
There are no safety net providers, initiatives or programs available territory-wide that promote support services such as transportation and care coordination to ensure regular and adequate care.
Birth certificate data is used to calculate this index. The VI does not participate in PRAMS or any other data/statistical collection and analysis effort to calculate the adequacy of prenatal care in all populations.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	54.8	30.0	30.0	55.0	54.0
Numerator	7785	1989	1698	3126	3096
Denominator	14210	6630	5663	5685	5734
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data not available or collected for this indicator by the Bureau of Health Insurance and Medical Assistance.
Estimates based on children seen in both districts with who were uninsured. Medical Assistance Program doesn't have presumptive eligibility and doesn't pay for services for potentially eligible children.

Notes - 2008
Data not available or collected for this indicator by the Bureau of Health Insurance and Medical Assistance.
Estimates based on children seen in both districts with who were uninsured. Medical Assistance Program doesn't have presumptive eligibility and doesn't pay for services for potentially eligible children.

Notes - 2007
Data not available or collected for this indicator by the Bureau of Health Insurance and Medical Assistance.
Estimates based on children seen in both districts with Medical Assistance coverage.

Narrative:
The MAP data system currently does not have the capability to generate specific claims data related to children and the services received. The Medical Assistance Program (MAP) functions under a cap for fiscal year 2006 and a ratio of Federal and Local matching of 50/50.
Medicaid funds allotted for USVI are capped and insufficient to provide services for all Medicaid eligible children and families. It is challenging to provide an accurate estimate of the number of children who received services paid by Medicaid funds. Medicaid is accepted at the government run health facilities. There are a limited number of private providers that accept Medicaid as a form of payment. This presents a unique challenge in reducing health disparities in that Medicaid clients cannot access the health care available in the private clinics. The MCH Program provides Medicaid enrollees or potentially eligible enrollees access to health care service regardless of insurance status.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	3.9	7.5	24.7	26.9	30.9
Numerator	65	126	445	606	477
Denominator	1681	1674	1798	2251	1544
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Data obtained from Division of Dental Services St. Thomas-St. John District..
Denominator is actual # of children receiving services.
Numerator is # of children age 6-9 years who received any service, including school based screening.

The Medical Assistance Program does not collect age specific claims data.

Notes - 2008
Data obtained from Division of Dental Services St. Thomas-St. John District..
Denominator is actual # of children receiving services.
Numerator is # of children age 6-9 years who received any service, including school based screening.

The Medical Assistance Program does not collect age specific claims data.

Notes - 2007
Data obtained from Division of Dental Services St. Thomas-St. John District..
Denominator is actual # of children receiving services.
Numerator is # of children age 6-9 years who received any service.

The Medical Assistance Program does not collect age specific claims data.

Narrative:
The Division of Dental Health Services continued to provide oral health care services, examinations and preventive services for the MCH population on a daily basis.
The School Outreach Program -- Sealants were applied for 471 children in FY 2009. Data is not collected by age, insurance type or race/ethnicity. The number of EPSDT eligible children is not known. The Medical Assistance program does not collect or report data applicable to this or any HSCI. (Further discussion under NPM #9).

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator					
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?					

Notes - 2009
This HSCI is not applicable to the Territory of the Virgin Islands.

Notes - 2008
This HSCI is not applicable to the Territory of the Virgin Islands.

Notes - 2007
This HSCI is not applicable to the Territory of the Virgin Islands.

Narrative:
This HSCI is not applicable to the V.I. SSI benefits are not available to children in this age group with disabilities. Rehabilitative services are provided through the Department of Education Special Education Program and the MCH & CSHCN Program.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of low birth weight (< 2,500 grams)	2009	other	2.2	3.3	5.5

Notes - 2011
Data sources for HSCI 05 - Prenatal and delivery statistics from DOH Community Health, MCH and 330 FQHC's (2).

Data for calendar year 2009 is incomplete at the time of submission of this report and is not available from the Office for Vital Records & Statistics.

The Medical Assistance Program does not collect or report this information

Narrative:
The VI Bureau of Economic Research, Office of the Governor in the US Virgin Islands (USVI) contracted with the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota, School of Public Health, to conduct the 2009 VI Health Insurance Survey. The telephone survey was conducted to assess current rates and types of health insurance coverage among adults and children in the US Virgin Islands. The survey was comparable to a survey undertaken in 2003, allowing for some comparisons in rates over time. This study found that approximately 28.7% (33,000) people were uninsured, up from 24.1% in 2003. This estimate is significantly higher than 7% higher than the rate for the entire US. 21% of the VI population was uninsured for the entire year. This is 9% higher than the equivalent measure for the entire US population.
Based on information collected in fiscal year 2009, an estimated 66% of children accessing services at the MCH program had Medical Assistance; 28% had no coverage and the remaining 6% had private or other group insurance. Any efforts to address elimination of health disparities in this population are severely hampered by stringent eligibility criteria of MAP. The poverty threshold for annual allowable income to qualify for Medicaid in the VI is $9,500 for a family of five compared to the national average of $23,497 (Census Bureau 2004) for a family of five. This requirement causes difficulty for uninsured families to qualify for Medical Assistance and creates barriers to health care resources and services. These uninsured individuals are generally unable to afford health insurance premiums and therefore not as likely to seek early prenatal care which may contribute to poor birth outcomes. The actual cost of providing Medicaid services to this population who would otherwise meet eligibility criteria is unknown. Government programs,

clinics and hospitals (3) provide health care services at little or no cost. Everyone, including low income, uninsured or underinsured individuals and families have access to essential services. Prenatal patients with Medicaid coverage do not have the ability under program requirements to access care at private providers which limits their choices of providers. In 2008, VIPI instituted the Perinatal Morbidity & Mortality Review Committee to determine the common clinical indicators leading to preterm births and fetal deaths.
Prenatal clinic providers continue to offer health education and counseling to pregnant women with complex medical and social risk factors associated with preterm and low birth weight infants. There is no valid data source available to compare the outcomes for Medicaid / non-Medicaid and all MCH populations. Medicaid records are not linked to Birth Certificate/Death Certificate records. This linkage which would address the challenges of accessing and reporting accurate data in a timely manner.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2008	other	2.2	4	6.2

Notes - 2011
Data sources for HSCI 05 - Prenatal and delivery statistics from DOH Community Health, MCH and 330 FQHC's (2).

Data for calendar year 2009 is incomplete at the time of submission of this report and is not available from the Office for Vital Records & Statistics.

The Medical Assistance Program does not collect or report this information

Narrative:
The territory lacks a MCH Epidemiologist who would be available to conduct analyses of infant deaths to identify groups at highest risk and to identify risk factors. The Bureau of Health Statistics does not collect or report insurance data on the certificate of live birth. It is anticipated that an electronic birth records database will provide this information in the future.
Medicaid claims or hospital discharge data is not available for comparison of Medicaid/non-medicaid population outcomes.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**

State					
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2009	other	17	27	44

Notes - 2011
Data sources for HSCI 05 - Prenatal and delivery statistics from DOH Community Health, MCH and 330 FQHC's (2).

Data for calendar year 2009 is incomplete at the time of submission of this report and is not available from the Office for Vital Records & Statistics.

The Medical Assistance Program does not collect or report this information

Narrative:
The Bureau of Health Statistics provides data for this measure. While the MCH & CSHCN Program does not have direct access to the data, estimates are provided based on prenatal patients who accessed care at public facilities but does not include women who received care at private providers. The Medical Assistance program does not have the ability to provide accurate data on paid claims for prenatal patients.
Virgin Islands Perinatal Inc.'s "Promoting Healthy Families Initiative" seeks to improve access for low-income, uninsured, under-insured residents diagnosed with high risk pregnancy, diabetes and/or hypertension by addressing barriers to care through outreach, case management, education, system integration and community awareness. From October 2008 to December 2009, PHFI served 71 high risk pregnant clients. 86.5% of enrollees had a normal birth weight, 13.5% had a birth outcome categorized as low birth weight. 44.4% had an educational level of 9-11 years, 80% had an income of less than $10,000. 45% of the high risk pregnant clients were without insurance. Despite targeted outreach, 73.5% entered into prenatal care in the second or third trimester.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2008	other	10.6	35	45.6

Notes - 2011
Data sources for HSCI 05 - Prenatal and delivery statistics from DOH Community Health, MCH and 330 FQHC's (2).

Data for calendar year 2009 is incomplete at the time of submission of this report and is not available from the Office for Vital Records & Statistics.

The Medical Assistance Program does not collect or report this information

Narrative:
Barriers to accessing early prenatal care include lack of providers at public facilities, inability to access private providers and lack of insurance coverage public or otherwise. VI does not participate in PRAMS therefore all data is obtained from the Bureau of Health Statistics, which does not collect insurance data. The Medical Assistance program does not collect or report required data for this measure.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2009	200
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2009	200

Narrative:
Due to the federal Medicaid cap which severely restricts provision of services to all eligible families, eligibility is determined at 200% of poverty level. There are no indications that Congress will change or increase this in the near future.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 5) (Age range 5 to 14) (Age range 15 to 21)	2009	 200 200 200
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 5) (Age range 5 to 14) (Age range 15 to 21)	2009	 200 200 200

Narrative:

See discussion in HSCI #3 & #6A. The waiver for SCHIP remains in effect. Though SCHIP funds have been increased to the territory, they continue to be utilized only for acute care for children who are covered by Medical Assistance.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2009	200
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2009	200

Narrative:
See discussion in HSCI #5A, 5B & 5C. Poverty level is determined at 200% of federal poverty guidelines. Eligibility is determined by household income.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	1	No
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	1	No
Annual linkage of birth certificates and WIC eligibility files	1	No
Annual linkage of birth certificates and newborn screening files	1	No
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State	1	No

discharges		
Annual birth defects surveillance system	1	No
Survey of recent mothers at least every two years (like PRAMS)	1	No

Notes - 2011

Narrative:
The MCH & CSHCN Program has the ability to access data via written request for program planning or policy purposes. Linkages with electronic databases that house the data are not available.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	No

Notes - 2011

Narrative:
YRBSS was not administered in 2007-2008, 2008-2009 or 2009-2010 school years. The Title V five year needs assessment includes items from this survey relevant to this HSCI.

IV. Priorities, Performance and Program Activities

A. Background and Overview

The Title V Maternal and Child Health Services Block Grant Program is operated as a single Administrative Unit within the Department of Health. The unit, headed by the Director of MCH & CSHCN, is responsible for conducting the statewide assessment of needs, agency management, program planning and implementation, policy development, and interagency collaboration. Within the Administrative Unit are Program Administrators on each island who supervise the financial and clinic management, and program activities.

In FY '09, MCH & CSHCN administered the following programs:

- Preventive and Primary Child Health Care
- Integrated newborn genetic/metabolic and hearing Screening
- Prenatal Care Services and Care Coordination
- Subspecialty Care Services

Throughout FY'09, the MCH & CSHCN Program continued to promote care coordination and collaboration among programs serving the special needs population. Outreach, education and case management activities for pregnant women were provided through the expanded V.I. Perinatal Inc., (Promoting Healthy Families-HCAP and Healthy Families, Healthy Babies Initiative).

Partners and collaborators who were actively engaged with the program to maximize sharing of resources included individuals from the Departments of Education, 330-funded Community Health Centers, Medical Assistance Program, WIC Program, Vital Statistics, Immunization, Dental Health, Family Planning, Nursing Services, Social Services, Infants and Toddlers Program, Community Partners, and Parent Advocates. Parent and consumer participation and involvement via the V. I. Alliance for Primary Care and the MCH Advisory Council were strengthened.

The MCH & CSHCN Program focuses on the well being of the MCH populations of women and infants, children and adolescents, and children with Special Health Care needs (CSHCN) and their families. The program places an emphasis on developing core public health functions and responding to changes in the health care delivery system. As a territory with significant shortages of pediatric medical services and limited existing services, the Virgin Islands faces many challenges to development of systematic approaches to population based direct care services. In the past few years, program activities addressed improvement of access to services low-income, underserved or uninsured families, identification of the needs of culturally diverse groups, especially non-English speaking and other immigrant groups, and recognition of changes brought about by lack of access to adequate health insurance coverage, public or private, for a significant percentage of the population. In addition, activities for children and youth with special health care needs focused on assuring pediatric specialty and sub-specialty services to children and families, integrating data systems, continuing collaborations with private and public partnerships, and integrating community based services.

B. State Priorities

The Virgin Islands MCH & CSHCN has identified the following top ten (10) priority needs for primary and preventive care services for pregnant women, mothers, and infants; preventive and primary care services for children; and services for children with special health care needs.

- To increase services to adolescents and young adults in all areas of primary and preventive care appropriate using a positive healthy youth development model.
- To increase the percent of CSHCN families' participation in transition planning to at least 50%.
- To improve and strengthen linkage of special needs children with needed health and community-based support services.
- Provide technical assistance, education, training materials and programs for community-

based family support organizations that serve the maternal and child population.

- To promote community partnerships.
- To improve access to prenatal care for medically underserved women and increase healthy birth outcomes; promote reproductive health services.
- To improve access to primary and preventive health care services for all segments of the MCH population.
- Ensure access to developmental screenings and evaluations for children that are identified as high-risk.
- Promote healthy lifestyle practices and reduce the rate of overweight children and adolescents through implementation of the CDC-WE CAN (Ways to Enhance Child Activity & Nutrition) Program.
- Enhance efforts to improve data collection and collaboration.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	99	100	100	95	95
Annual Indicator	100.0	100.0	86.7	40.3	70.0
Numerator	27	25	130	81	70
Denominator	27	25	150	201	100
Data Source				NBS Program	NBS Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	95	95	95	95	95

Notes - 2009
Denominator for 2009 reflect s initial positives for for expanded screening - total 48 disorders.

Numerator for 2009 reflects rescreening, final diagnosis, counseling and/ or enrollment in appropriate treatment for identified disorder.

All data obtained from the Newborn Screening Database.

Notes - 2008
Denominators for 2005/2006 reflect initial positives for limited screening: TSH, PKU. MSUD, Homocystinuria, Hemoglobinopathies, Galactosemia, and G6PD.

Denominators for 2007/2008 reflect initial positives for expanded screening - total 48 disorders.

Numerators for 2005-2008 reflect rescreening, final diagnosis, counseling and enrollment in appropriate treatment for identified disorder.

All data obtained from the Newborn Screening Database.

Notes - 2007
Denominator reflects number of children initially screened positive for sickle cell disease, hypothyroidism and G6PD. While there were initial positives in other categories, e.g. biotinadase, galactosemia, cystic fibrosis and PKU, follow-up testing was normal and further medical management was not needed or recommended.

Numerator reflects number of children re-screened with confirmatory diagnosis made.

a. Last Year's Accomplishments
Initial newborn screening was transitioned to both hospitals during fiscal year 2009. MCH & CSHCN role is to ensure follow-up of reported positive results, and comprehensive medical care and management care for all children identified through screening with an inheritable disorder Newborns were screened for 48 inheritable disorders by Perkin Elmer Genetic Screening Laboratory using mass spectrometry. Some of the disorders include but are not limited to: sickle cell hemoglobinopathies, galactosemia, hypothyroidism, G6PD, acylcarnitine and amino acid profiles, cystic fibrosis and biotionidase deficiency. Patients and families with positive results receive genetic counseling, case management and comprehensive care within 2 months of diagnosis.
For CY 2009, 74 % of newborns in the territory were screened. Three (3) children were identified with sickle cell disease, and one (1) with congenital adrenal hyperplasia. Program staff continued follow-up efforts to assure all infants with abnormal lab results were followed until diagnosis or are determined to be lost to follow-up.
A Hematology Clinic meets monthly and offers sub-specialty consultation with a board-certified pediatric hematologist. The clinic is integrated within the primary care pediatric clinics. This service is provided in both districts.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Achieve 99% initial screening of infants for selected genetic / metabolic disorders.			X	
2. Follow-up and track infants with unsatisfactory or abnormal results.	X	X		
3. Refer all children with a diagnosed metabolic/genetic disorder for appropriate follow-up and treatment.	X	X		
4. Refer all children identified with significant hemoglobinopathy for Pediatric Hematology evaluation and diagnosis by 4 months of age.	X	X		
5. Board certified Pediatric Hematologist continues to provide service on a contractual basis.	X			X
6. Develop referral mechanism for off-island pediatric metabolic / genetic centers.	X	X		
7. Utilization of an integrated newborn genetic-metabolic and hearing screening database for tracking and surveillance.			X	X
8. Update and distribute newborn screening brochure to providers and parents.			X	X
9. Update and distribute newborn screening brochure to providers and parents.	X	X	X	

10. Continue to work towards development of data linkage of newborn screening records and birth certificates.			X	X

b. Current Activities

Prevention of morbidity and mortality due to early identification, treatment and management continues to be successful. No deaths reported due to complications during this fiscal year. 100% of newborns confirmed with sickle cell disease are entered into a comprehensive system of care.

This fiscal year two (2) infants were diagnosed with sickle cell or other hemoglobin variant disease. 100% are enrolled in comprehensive care and receive prophylactic penicillin. Newborns identified with sickle cell trait remains constant at 1 in 8 of those screened. Trait counseling is offered to parents and families of these newborns.

Their families receive on-going education and counseling on sickle cell disease management. Dr. Condon Richardson, a local pediatric hematologist conducts monthly hematology clinics on both islands.

The increased number of children with complicated sickle cell disease which requires the use of Hydrea, areclosely monitored for side effects or compliance issues. A program of specialized health care to address the specific needs of adolescents with sickle cell (coping skills, dating, sexual practices, the risks of pregnancy, transitioning to high school and then college with sickle cell disease) was started. The program provided educational material about these issues, implemented talk sessions and established a teenage support and counseling group for those adolescents with sickle cell disease.

c. Plan for the Coming Year

Follow-up testing is provided for all abnormal and / or unsatisfactory results to assure completion of screening.

Patients and families with positive results will receive access to genetic counseling, case management and comprehensive care. Sub-specialty consultation with a board-certified pediatric hematologist will continue to be available. Parent support group activities on each island will continue.

The integrated newborn metabolic/genetic/hearing tracking and surveillance database will provide useful information for statistical reporting and tracking.

The program anticipates that the 100% follow-up rate for entry into comprehensive medical care for children diagnosed with sickle cell disease or other metabolic disorder will be maintained.

Public health nurses continue to follow-up this special needs population by provision of case management and care coordination services.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**1755**			
Reporting Year:	**2009**			
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**	**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment**

					(3)	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	1291	73.6	1	0	0	
Congenital Hypothyroidism (Classical)	1291	73.6	2	0	0	
Galactosemia (Classical)	1291	73.6	4	1	1	100.0
Sickle Cell Disease	1291	73.6	3	1	1	100.0
Cystic Fibrosis	1291	73.6	2	1	1	100.0
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	1291	73.6	2	1	1	100.0
Hearing Screening	1580	90.0	6	1	1	100.0
G6 Phosphate Dehydrogenase	1291	73.6	80	65	65	100.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	30	50	30	30	40
Annual Indicator	49.0	22.5	20.0	12.2	4.7
Numerator	563	235	250	187	70
Denominator	1149	1044	1248	1530	1505
Data Source				HealthPro/MCH	Client Satisfaction Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	40	40	40	45	50

Notes - 2009
Numerator based responses to client satisfaction survey during March-April 2010 in St. Thomas-St. John District.

Notes - 2008

VI is participating in National CHSCN Survey this year. Data for this measure obtained from MCH nursing staff in St. Thomas-St. John District.

Denominator obtained from Health Pro database.

Notes - 2007
The numerator reported in 2007 is obtained from clinic data from St. Thomas only.

a. Last Year's Accomplishments
Program nurses, physicians and allied health staff continued to work with families to make decisions about care and services for children. Meetings and case conferences attended during this period focused on transition from early intervention programs to school; children with special needs in the foster care system; and collaborations between public health nurses and families.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Families are represented on the MCH Advisory Council. Involve families in task forces, advisory and planning committees.		X		X
2. Encourage family members participation in development of parent education materials and fact sheets.		X		X
3. Parent advocacy organizations are program partners and provide training, resources and services.		X		
4. Continuation and strengthening of existing linkages and referral network.		X		X
5. Encourage family representation at the annual AMCHP meeting.		X		X
6. Support opportunities for family members to attend local or national conferences, meetings and workshops.		X		
7. Provide compensation for family participation in program activities, conferences, meetings.		X		X
8. Program staff assists families with identifying needed resources.		X		X
9. Develop and administer exit surveys to determine satisfaction after clinic visits.		X	X	X
10. Develop and administer annual family satisfaction surveys.		X	X	X

b. Current Activities
The program continues to focus most of the personnel time and other resources toward provision of direct health care services to children and their families.
Family members participate on the V.I. Alliance for Primary Care and MCH Advisory Council. Bi-lingual family members are recruited for participation on these committees.
The program did not meet the characteristics of family members of children with special health care needs as paid staff or consultants specifically for the purpose of family advocacy. However, there are several administrative staff members who are parents of special needs children who access sub-specialty services and function as advocates when necessary.
The program continued partnership with Early Head Start-Lutheran Social Services and PreSchool Education Program-Department of Education to develop and distribute information cards on health, early intervention and relevant services for the early childhood population. These cards list available services and contact numbers and are available at all Head Start and child care centers, clinic sites and various community partners offices throughout the territory.

c. Plan for the Coming Year

The Virgin Islands Title V Program plans to address this measure through continuation and strengthening of existing linkages and referral network.

Other strategies to be employed are: expand outreach and support to culturally diverse populations, providers and community organizations; identify barriers that prevent families from accessing health care on a regular basis; encourage family-professional partnerships in all program activities, i.e. include families in all workgroups, advisory committees and provide adequate compensation for their time; and encourage and promote participation in parent mentor/support groups to families, family advocacy organizations and providers.

Activities to develop and implement an action plan to enhance services for families of children with special needs including training for parents and families will be achieved based on available financial resources.

Develop and administer annual family satisfaction surveys. These are available in English and Spanish. Other actions to achieve this goal are to continue coordination with Child Find activities in Part C-IDEA Program, Department of Education-Special Education, Pre-School Education & Head Start Programs, and encourage participation through culturally sensitive and appropriate family training and education.

Training for staff, families and providers towards achievement of this goal will be provided in collaboration with a program partner, V.I. Family Information Network on Disabilities (VIFIND). This community based advocacy agency teaches parents about their rights under the Americans with Disabilities Act, IDEA and Section 504 of the Rehabilitation Act, and empowers them to actively participate in decisions affecting their child with special needs. Parents are assisted to locate information, resources, programs and services, and to communicate effectively with professionals and services providers.

Families will be asked to participate in the pilot survey for one part of the obesity project and to participate in giving suggestions about methods to implement the WE CAN program that will be effect in meeting the needs of our population.

Continue program staff participation in family support and advocacy organizations.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	20	55	50	50	55
Annual Indicator	50.6	43.5	38.1	54.6	39.9
Numerator	581	454	475	835	600
Denominator	1149	1044	1248	1530	1505
Data Source				HealthPro/MCH	MCH Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	60	60	60	60	65

Notes - 2009
More than half of all CSHCN with high complexity diagnoses receive care coordination services at MCH clinics in both districts.
These services meet the American Academy of Pediatrics defines the medical home as “a model of delivering primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care.

Denominator obtained from MCH clinics monthly reports.

Numerator reflects estimate of number of children requiring care/service coordination by public health nurses, are considered to have complex medical diagnoses; require home visits, IEP's, and multi-specialty services.

Notes - 2008
More than half of all CSHCN with high complexity diagnoses receive care coordination services at MCH clinics in both districts.
These services meet the American Academy of Pediatrics defines the medical home as “a model of delivering primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care.

Denominator obtained from HealthPro database.

Notes - 2007
The numerator reported in 2007 is obtained from clinic data from St. Thomas only.

a. Last Year's Accomplishments
The definition of "Medical Home" as it's applied on the US mainland has a different meaning in the territory. The Title V program is considered the medical home as defined by the American Academy of Pediatrics, for a large percent of the CSHCN population. For many families the medical home is where a child with special health care needs and his or her family can count on having medical care coordinated usually by a public health nurse or service coordinator with the involvement of the pediatrician. These nurses and families work together and access all of the medical and non-medical services needed to help CSHCN achieve their potential. Factors that contribute to this are increasing numbers of underinsured and uninsured families; welfare to work policies for single head of household families that offer low paying jobs with little or no medical insurance benefits or paid days off; and an overall poverty rate of 43.6% for children under 18 years in the territory in single parent homes. In addition, private pediatricians and other primary care providers routinely refer families to the program for access to specialty care not otherwise available.
The 330 funded health centers remain without full-time pediatricians. This places severe limitations on their ability to provide medical homes.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Encourage families of CSHCN to access comprehensive care through a medical home.		X		X
2. All primary and specialty care is coordinated by public health	X	X		

nurses in the Title V program.				
3. Continue to promote medical home through partnerships and collaboration with community-based organizations and other agencies that serve the special needs population.				X
4. Educate families of children with special health care needs of the importance of medical home .		X		X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Families with private or group insurance may opt to remain with a private provider for primary care and access Title V services for specialty or sub-specialty care only.
The program authorizes medical, laboratory and diagnostic care, and other treatment services including rehabilitative services, for children who are uninsured or families are determined to have the inability to otherwise pay for services.
The program continues to provide medical homes for children with special health care needs. Public health nurses continued to provide care coordination. Interventions included advocacy, education, case management, counseling, and nursing procedures. Services were provided in a variety of locations including in the home, by phone and in other locations such as hospital, clinics or school or child care setting.

c. Plan for the Coming Year

Existing partnerships such as those with the non-profit 330 FQHC's, private pediatricians and the Part C-IDEA Program will be utilized to plan, develop and implement an on-going training program.
A plan to promote the medical home approach through collaborations with community based organizations and professionals, i.e. child care providers, will assure their assistance in encouraging families to access the comprehensive and coordination available in a medical home.
Reconvene the medical home task force to implement a plan to promote the medical home approach.
Parents are encouraged within their financial confines to establish a relationship with a private pediatrician.
Establish data collection mechanism to monitor, track and determine positive outcomes and successful achievement of HP 2010 Objective 16.22 - Increase the proportion of children with special health care needs who have access to a medical home (Developmental).
Promote the use of Bright Futures, which is a tool and a best practice for increasing quality of health care and health education for children and families. This will assist the program in furthering the goals of the MCH Priorities.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		30	35	35	35

Annual Indicator	27.0	43.5	25.0	52.0	8.3
Numerator	310	454	312	795	125
Denominator	1149	1044	1248	1530	1505
Data Source				HealthPro	MCH Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	35	40	40	50	50

Notes - 2009
Numerator obtained from MCH clinics in both districts reflects families reporting a source of insurance other than Medicaid.

Denominator obtained from MCH clinics monthly reports.

52% of families accessing care at MCH Program report no source of insurance.

Notes - 2007
Numerator obtained from MCH clinics in both districts reflects families reporting a source of insurance other than Medicaid.

a. Last Year's Accomplishments
This measure is not directly applicable to the territory. There is a Medicaid cap that places severe limitations on the ability to provide insurance for eligible families. SCHIP funds are utilized to pay unpaid medical expenses for children with Medicaid.
There are no HMO's, MCO'S or PPO's providing Medicaid managed care coverage.
Some private sector employers provide medical benefits for their employees with no family coverage options.
The population known to be below the federal poverty level is presumed eligible for Medical Assistance. However, the poverty threshold for annual allowable income to qualify for Medicaid in the VI is $9,500 for a family of five compared to the national average of $23,497 (Census Bureau 2004) for a family of five. This requirement causes difficulty for uninsured families to qualify for Medical Assistance and creates barriers to health care resources and services. These uninsured individuals are generally unable to afford health insurance premiums and therefore not as likely to seek preventive or primary care. The actual cost of providing Medicaid services to this population who would otherwise meet eligibility criteria is unknown. Government programs, clinics and hospitals (3) provide health care services at little or no cost, everyone, including low income, uninsured or underinsured individuals and families have access to essential services. Families of children with special needs who have insurance through MAP have limited ability under program requirements to access care at private providers which restricts their choices of providers. Children with special health care needs usually require a higher and more comprehensive level of health care beyond that required by normal children and are more likely to experience catastrophic illnesses. These populations of children and families generally have extremely low incomes and are more likely to be uninsured. Children with health insurance are likely to obtain adequate health care therefore insurance coverage and the type and extent of coverage is an important indicator of access to care. Children who are under/uninsured usually have more emergency room visits and hospitalizations, and time lost from school. Adequate insurance allows access to comprehensive care, which in turn reduces emergency room visits,

hospitalizations, and time lost from school or work.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Title V program provides access to specialty and sub-specialty services	X	X		X
2. All children in the territory have access to these services regardless of source of payment or ability to pay for services.		X		X
3. Refer all families without insurance to Medical Assistance program to determine eligibility.		X	X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A sliding fee scale is available for clinic services. Income eligibility is based on 250% of the federal poverty income guidelines.

The Government of the Virgin Islands requires all of its employees to be covered by group medical insurance. The current carrier, CIGNA, is considered a PPO with most local providers a part of the network.

Families without health insurance are less likely to have a regular source of care and access the health care system only when necessary in order to avoid out-of-pocket costs.

The Title V program provides access to services, i.e. diagnostic, laboratory, specialty and sub-specialty care for families with no insurance coverage who are not eligible or do not meet certification standards for the Medical Assistance Program.

c. Plan for the Coming Year

The program will continue to provide sub-specialty clinics to children with special health care needs utilizing contracted pediatric sub-specialists. Sub-specialists from Puerto Rico conduct monthly clinics in pediatric neurology, orthopedics, hematology and cardiology. All children in the territory have access to these services regardless of source of payment or ability to pay for services. The availability of these services has reduced the high cost of off-island travel, enabled the clinics to be community-based, increased communication, reduced lost time from work for parents/caregivers, and enhanced the quality and continuity of care. Off-island referrals are primarily for diagnostic services such as cardiac catheterization, cardiac sonography, brainstem audio-evoked response testing, and less frequently, oncology, endocrinology, gastro-enterology and neuro-psychology services that are not available on-island for the pediatric population.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	30	50	30	30	35
Annual Indicator	50.0	19.4	14.8	0.0	0.0
Numerator	574	203	185	0	0
Denominator	1149	1044	1248	1530	1505
Data Source				MCH Program	MCH Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	35	40	40	40	40

Notes - 2009
Information for this measure was not collected.

Questions related to this measure were included in the 2010 Needs Assessment.

Notes - 2008
Information for this measure was not collected.

Notes - 2007
Numerator reflects # of referrals to community based services in both districts include after-school programs, family support and advocacy programs.

a. Last Year's Accomplishments
Efforts to strengthen relationships with other community providers to coordinate services, reduce duplication of services, determine unmet needs, and assure that the children requiring services receive them continued.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Families are referred to appropriate community service agencies or organizations.		X		
2. Maintain and periodically update as needed a resource directory of all community-based services and organizations.		X	X	X
3. Continue to assist families in accessing services based on identified needs.		X		
4. Develop and implement a referral / feedback system for tracking purposes.		X		X
5. Develop guidelines for minimum standards of service system of care development.				X
6. Create a single point of referral for service coordination across		X		X

agencies to maximize usage of resources for services.				
7.				
8.				
9.				
10.				

b. Current Activities
The program provided information and referral services to appropriate agencies based on families identified needs.

c. Plan for the Coming Year
Build on existing collaborative partnerships with community based organizations that provide services to children and families. These include but are not limited to advocacy groups, legal services, resource and training centers, child care providers, family support and faith based organizations.
Provide technical assistance and consultation for community-based organizations that serve our maternal and child population.
Provide education, training materials and programs for community and community organizations that serve both mothers and children in the territory.
Continue to assist families in accessing services based on identified needs.
Develop and implement a single point of referral for service coordination across agencies to maximize usage of resources for services.
Utilize a referral / feedback system for tracking purposes and to determine outcomes of services provided.
Continue efforts to implement family-centered, culturally competent, and community-based systems of referral and care and to simplify access to these systems for families.
Periodically evaluate referral system to assure that it is consistent with the Title V vision to integrate and strengthen community-based programs into a system of services that is more accessible and responsive to families and communities.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		30	30	35	20
Annual Indicator	20.5	2.6	1.2	0.7	0.3
Numerator	235	27	15	11	5
Denominator	1149	1044	1248	1530	1505
Data Source				MCH Program	MCH Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

	2010	2011	2012	2013	2014
Annual Performance Objective	20	20	25	25	25

Notes - 2009
Numerator reflects data provided by MCH Nursing in St. Thomas-St. John District.

Notes - 2008
Numerator reflects data provided by MCH Nursing in St. Thomas-St. John District.

Notes - 2007
Numerator reflects the # of youth who transitioned to adult health care services in St. Thomas-St. John District.

a. Last Year's Accomplishments
The program utilized a plan for youth and adolescents with special health care needs transitioning to adulthood. The plan is based on the Healthy and Ready to Work model which facilitates the integration of service systems to address the health issues of this population. Public health nurses ensured appropriate referrals for all adolescent and young adult clients to the appropriate agencies for health/school/work transition.
The plan supports skill-building opportunities for youth and their families. It supports their involvement as decision makers in their health care, education and employment.
Improvement in transition activities related to increasing family /youth advocacy and connecting families/youth with information regarding community / university resources for educational and vocational planning.
Collaboration and coordination continued with several agencies to assure effective transition - Departments of Education, Vocational Education; Department of Human Services, Vocational Rehabilitation; Department of Labor, Job Training and Placement; Community Health and 330 Centers; community based organizations, i.e. V.I. Resource Center for the Disabled, University of the Virgin Islands Center for Excellence on Developmental Disabilities, Virgin Islands Assistive Technology Foundation, Inc., Family Voices, V.I. Center for Independent Living, and V.I. Family Information Network on Disabilities.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop transition plan in collaboration with Vocational Education, Department of Education, adult health care services and other appropriate agencies.		X		X
2. Facilitate interagency collaboration to share resources and skills.		X		X
3. Provide transition information to families.	X	X		
4. Solicit and encourage family and adolescent participation in transition planning.	X	X		
5. Establish data collection mechanism to monitor and track successful and effective transition.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Transition planning with families provided by public health nurses. Established transition planning checklists are utilized.

c. Plan for the Coming Year

Facilitate interagency collaboration to share resources and skills.
Use information received from the needs assessment to promote transition planning from pediatric to adult health care.
Continue to utilize, implement and evaluate transition planning health care plans for families of all children and adolescents with special health care needs. Continue collaboration with other agencies and community-based partners to address health care transition issues.
Encourage adolescents to participate in transition planning and provide age appropriate transition services.
Establish data collection mechanism to monitor and track successful and effective transition.
Use data to determine positive outcomes and achievement of HP 2010 Objective 16.23 - Increase the proportion of Territories and States that have service systems for children with special health care needs (Developmental).

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	90	90	70	70	70
Annual Indicator	45.7	63.0	80.0	31.2	60.5
Numerator	467	382	943	215	348
Denominator	1023	606	1179	690	575
Data Source				MCH Program	MCH Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	75	75	75	75	75

Notes - 2008

Data remains unavailable from VI Immunization Program. The National Immunization Survey is currently being conducted this fiscal year.

Denominator obtained from children in this age group receiving any service at MCH clinics in the St.Thomas-St. John District.

Numerator reflects number of children in this age group with complete immunizations at MCH clinic in the St. Thomas-St. John District.

Notes - 2007

Data reported for this measure was provided by the MCH clinic in the St. Croix district only which is collected manually. This does not reflect territorial data. Denominator is the total # of children in this age category who received any immunizations. Numerator is the number who meet the requirements of this measure.
The VI Immunization Program does not have a database system in place to provide territorial information for this measure

a. Last Year's Accomplishments
Technical and contractual challenges and deficiencies with the Immunization Registry are not resolved according to Immunization Program staff. Data required for this performance measure remains unavailable from the Immunization Program.
MCH nurses and physicians ensure that infants and children receive age appropriate immunizations well child visits, primary and preventive care visits.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assessment of immunization status included in each primary and preventive care visit.	X		X	
2. Continue WIC immunization linkage.			X	
3. Families are provided literature on AAP/CDC Guidelines on Immunizations.	X	X	X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Women, Infants and Children Nutrition Program (WIC) ensured that children participating in the program completed their immunization schedule through age 2. Participants who are not up to date with their immunization are referred to the Immunization Clinic as per Memorandum of Understanding that VI WIC has with the immunization program according to policy and procedure 2.09.
Immunizations continue to be a vital part of every primary and preventive care visit at MCH clinics, the community heath centers and other clinics.
MCH staff participated in training activities sponsored by the Immunization program.
Vaccine for children not eligible for VFC program is purchased by the program to ensure that vaccine is available to ensure compliance with standard immunization guidelines.

c. Plan for the Coming Year
The Vaccine For Children Program's mandate related to uninsured or Medicaid eligible/certified children can qualify to receive vaccine through from the program will continue to be implemented.
The program will continue to strive for at least 95% of all children receiving services will have complete recommended immunizations by age 3 through continuous review of immunization status and parental education.
This is especially crucial since the VIDOH Immunization Registry does not have the capability to produce valid and / or reliable data for reports. Immunization will continue to be a vital part of

every primary and preventive care visit at MCH clinics, the community heath centers and other clinics.
MCH program will continue to assure access to vaccines that are required for child care and school entry, and maintain access to vaccines that are indicated in some high risk children.
In order for MCH & CSHCN clinical staff to keep up with ever changing immunization policies, promote attendance at training sessions and annual immunization conference.
Continue efforts to raise immunization rates through promotion of awareness by means of outreach activities, distribution of parent education, identification of children who are not up to date.
Continue WIC linkage.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	20	15	15	15	15
Annual Indicator	22.0	16.4	16.4	9.8	49.9
Numerator	67	60	60	36	183
Denominator	3039	3667	3667	3667	3667
Data Source				Vital Records	Prenatal Clinics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	15	15	15	15	15

Notes - 2009
Data on 15-17 year females is not reported as a separate category in the VI Community Survey.

Numerator reflects number of females 15-17 years receiving prenatal care at DOH Community Health, MCH Prenatal and 330 FQHC's (2) during calendar year 2009.

Data not available for this reporting year from Office for Vital Records & Statistics.

a. Last Year's Accomplishments
Provided information to adolescents on topics (age appropriate) such as delay in sexual activity; sexual coercion; abstinence; refusal skills; and protection against STDs and HIV/AIDS.
Sessions were held at public schools, juvenile centers, faith based organizations, and summer camps.
In 2009, 195 educational sessions were held with 2,378 teens participating.
Over 500 sexually active teens received services and/or contraceptive supplies at no fee. This means that 500 plus unintended pregnancies have been prevented. This saves the V.I. Government at least $1,500,000 (@ $3,000 per live birth) in services to these teens and their babies.
Over 500 on site tests for Chlamydia/Gonorrhea were done on teens, and the positives were

treated while their partners were referred to the STD Program. This is critical in light of the alarmingly high Chlamydia rates (18.8% in 2008 versus US Mainland's 5 -- 8 %) among teens in the V.I. (Data generated from Region II Infertility Report 2008)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide and promote referrals to the Family Planning Program's adolescent health outreach services.	X		X	
2. Provide access to comprehensive services, STD counseling and testing for adolescents.	X		X	
3. Continue to engage adolescents through outreach activities that emphasize responsible decision making.	X	X	X	
4. Group sessions and other activities to promote wellness among the teen population.	X	X	X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Family Planning programs continued efforts to decrease teen births by providing confidential counseling and contraceptive services.

FP program staff continues to support teen pregnancy prevention activities by engaging adolescents through outreach activities that emphasize responsible decision making; education related to STD prevention and provision of clinical services. Staff continues providing education and outreach for clients aged 15-17 on reproductive health topics such as abstinence, decision making skills, healthy relationships, male responsibility, parent-child communication, safer sex, sexual responsibility, teen pregnancy issues and sexually-transmitted infections.

c. Plan for the Coming Year

The Family Planning Program will continue to strive to increase awareness, especially to adolescents on choices and consequences as it relates to sexual involvement. Outreach staff will continue to provide sessions specifically for teens.

Encourage adolescent male involvement in family planning outreach activities emphasizing shared responsibility and STD/HIV prevention..

The Family Planning Program will continue to provide access to comprehensive services, STD counseling and testing, with special counseling for adolescents.

Outreach and community education efforts will continue to provide information through print, radio and TV media.

Group sessions and other activities are being planned to promote wellness among the teen population.

Increase access to teens at high risk for unintended pregnancies and STD through the Implementation of Satellite Teen Clinics on St. Thomas and St. Croix.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	30	35	35	20	10
Annual Indicator	0.0	1.4	1.1	8.5	
Numerator	0	126	87	606	
Denominator	9016	9016	7866	7130	
Data Source				Dental Program	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	15	15	15	20	20

Notes - 2009
Data for this denominator obtained from the VI Community Survey by the Eastern Caribbean Center - University of the Virgin Islands.

Numerator obtained from the DOH Division of Dental Services for the St. Thomas-St. John District. St. Croix District doesn't collect or report data for this measure.

Notes - 2008
Data for this denominator obtained from the 2006 VI Community Survey by the Eastern Caribbean Center - University of the Virgin Islands.

Numerator obtained from the DOH Division of Dental Services for the St. Thomas-St. John District.

a. Last Year's Accomplishments
Dental services are available at clinics administered by the Department of Health. Services include: examinations, fluoride applications, fillings and extractions. The Medical Assistance Program (MAP) does not cover this service for enrolled children.
It is not anticipated that the Medicaid Program will have the resources to cover this service for VI children. Dental clinics will continue to provide other oral health services, including assessment, oral examination, fluoride applications, restorative fillings and extractions.
The Division of Dental Health continued its school-based preventive program and Head Start screening programs in 2009. In the St. Thomas/St. John District 1,544 or 97% of the students in the public, private and parochial schools, grades kindergarten, fifth and ninth grades were screened and received fluoride applications.
471 children received protective sealants. 677 children received screening exams in the dental clinic. The Medical Assistance program does not collect or report this data.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promote use of protective sealants.			X	
2. Screening and assessments for other dental conditions, preventive dental care and referral as appropriate.	X		X	
3. Collaborate with WIC Program and Division of Dental Health Services to promote early start of good oral health practices.	X		X	
4. Partnership established with territorial pediatric dentist to provide increased access to dental services	X		X	X
5. Develop and implement a data collection mechanism to assure the targeted population is receiving oral health services.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Title V Program provided financial assistance for CSHCN requiring surgical or periodontal treatments who were not covered by the Medical Assistance Program or were uninsured.
Dental clinics continue to provide other oral health services, including assessment, oral examination, fluoride applications, restorative fillings and extractions.
The School Based Preventive Program was discontinued due to the resignation of the dentist at the start of this fiscal year.

c. Plan for the Coming Year

The water supply in the Virgin Islands is not fluoridated. The use of sealants and fluoride has been proven to reduce or eliminate decay in the permanent teeth of children.
Partnership established with the pediatric dentist to assist the program in providing the spectrum of oral health services especially to the CSHCN population will be continued. This partnership is anticipated to address community needs related to oral health and provide education to students, families, child care providers and other professionals related to maintaining healthy teeth, prevention of tooth decay and proper nutrition.
In addition, they will provide improved increased access to dental services and expand sources of protective sealants.
Promote prevention activities related to oral health education targeting the general public in collaboration with the Division of Dental Services.
Training for physicians and other health care providers in oral health screening as part of routine health care will be undertaken.
Develop and implement a data collection mechanism to assure the targeted population is receiving oral health services.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	3	3	2	2	2
Annual Indicator	0.0	0.0	11.6	4.4	4.5

Numerator	0	0	3	1	1
Denominator	25996	25996	25805	22697	22458
Data Source				OHS	VICS / OHS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	1	1	1	1	1

Notes - 2009
Denominator obtained from 2007 VI Community Survey, Eastern Caribbean Center, University of the Virgin Islands.

Numerator obtained from the Office for Highway Safety, 2009 Traffic Data Report.

Notes - 2007
Data provided by the Office for Highway Safety, VI Department of Public Safety. Numerator reflects territorial data.

a. Last Year's Accomplishments
This data is not available from the Office of Vital Records and Statistics.
There is not a Child Death Fatality Review Committee in the VI.
VI Office for Highway Safety reported 1 fatality in this age group as a result of injuries caused by motor vehicle collision. However, this is not substantiated by data from DOH Bureau of Health Statistics which reports no deaths occurred.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to partner with VI-EMS and Office of Highway Safety (VIOHS) to promote injury prevention and traffic safety activities in the community.			X	X
2. Continue to raise awareness on the importance of seat belt use and child passenger restraint seats.			X	
3. Increase public awareness activities to include alcohol and other substance abuse safety issues as related to motor vehicle use.			X	X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

There are no official reported deaths in this age group due to motor vehicle crashes.
The Emergency Medical Services training staff provided injury prevention, infant and child safety, traffic safety including bike, skating, and motor vehicle passenger safety education to students, school staff, community organizations and other providers throughout the year. In addition, first responder and basic cardio-pulmonary resuscitation training were offered.
A pubic awareness and information campaign utilizing public service announcements and print media related to injury prevention is on-going.
The Office of Highway Safety (VIOHS) has an on-going media campaign regarding substance use (alcohol and other drugs) and driving.
VIOHS strategies to reduce crashes, injuries and deaths include activities in reducing alcohol related deaths, increasing safety seat belt usage, proper use of child restraint seats, and reducing pedestrian deaths.

c. Plan for the Coming Year
The program will continue to partner with VI-EMS and Office of Highway Safety (VIOHS) to promote injury prevention and traffic safety activities in the community.
Continue to raise awareness on the importance of seat belt use and child passenger restraint seats through presentations, outreach fairs and child safety seat clinics.
School-based health center providers will be included in this partnership.
Increase public awareness activities to include alcohol and other substance abuse safety issues as related to motor vehicle use.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		50	50	45	45
Annual Indicator	49.5	45.5	43.8	30.3	3.0
Numerator	830	800	775	558	52
Denominator	1676	1760	1771	1844	1755
Data Source				WIC/PedNSS	WIC/NBS Database
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	50	50	50	50	50

a. Last Year's Accomplishments
The Virgin Islands WIC Program continues all efforts to actively promote, support and protect breastfeeding within the territory. VI WIC continues to remain the 'beacon of light' for breastfeeding promotion within the islands, as the only organization, which consistently promotes and supports breastfeeding within the territory.
Provided breastfeeding information to all prenatal clients at certification as well as individualized assistance to breastfeeding moms with problems.

Nutrition Education and WIC program materials translated in Spanish are available to serve the Spanish speaking population.
Trends in the breastfeeding rate in the Virgin Islands have shown a steady increase from 67% in 1988 to an average of about 86% in 2009.
WIC participates in the Pediatric Nutrition Surveillance System (PedNSS).

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The VI WIC Program promotes breastfeeding through community and public awareness education activities using television, radio and print media.			X	X
2. Provide literature on breastfeeding to prenatal and postpartum clients.		X	X	
3. All WIC waiting room areas are breastfeeding friendly.	X	X	X	
4. Discharge surveys to breastfeeding mothers provide a mechanism to monitor breastfeeding rates.	X		X	X
5. Continue to coordinate breastfeeding activities with the WIC Program for pregnant women, mothers and infants.	X	X	X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities
To ensure that the WIC Program continues to promote, support and protect breastfeeding among WIC participants.
Continue efforts to ensure mothers that breast milk alone is sustainable to babies for up to six months. WIC will also continue to provide support for breastfeeding mothers who work.
Breastfeeding rates continue to be high in the Virgin Islands with a territorial initiation rate of 86% and an exclusive breastfeeding rate which continues to remain at 3% for the past 3 years. Moms are continually encouraged to breastfeed and are very comfortable breastfeeding in WIC clinic settings.
WIC participants continue to receive breastfeeding information and assistance that help to support breastfeeding efforts.

c. Plan for the Coming Year
Increase breastfeeding among new mothers by providing direct support and counseling in both WIC and MCH Clinics.
Maintain breastfeeding rates among new mothers by providing direct support and counseling in both WIC and MCH Clinics.
Maintain a breastfeeding environment within the WIC Program so that breastfeeding continues to be chosen as the preferred method of infant feeding by WIC mothers.
To promote, protect and support breastfeeding among WIC mothers.
Provide counseling, support and assistance to WIC moms with breastfeeding problems.
To implement the WIC Breastfeeding Peer Counselor Initiative.
To procure breast pumps and other breastfeeding aides for use in WIC clinics.
Continue coordination activities with the WIC Program to achieve HP 2010 Objective 16-19a - Increase the proportion of mothers who breastfeed their babies in early postpartum period.
Provide WIC clients with adequate nutrition education to make informed, lifestyle change

decisions, using effective nutrition education interventions.
Provide breastfeeding information and aides to breastfeeding moms so that they may have a successful breastfeeding experience.
Provide counseling, support and assistance to WIC moms with breastfeeding problems.
The Title V program will continue to coordinate breastfeeding activities with the WIC Program for pregnant women, mothers and infants. This includes referrals for care from WIC to the MCH program and from MCH to WIC. Public health nurses will use opportunities to promote and support breastfeeding.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	95	96	96	90	90
Annual Indicator	95.3	85.3	79.3	92.7	91.5
Numerator	1607	1501	1405	1709	1606
Denominator	1686	1760	1771	1844	1755
Data Source				NBS Program	NBS Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	95	95	95	95	95

Notes - 2009
Numerator reflects screening during birth admission. Infants missed received outpatient screening.

Denominator reflects number of live birth admissions.

a. Last Year's Accomplishments
The integrated newborn screening database was modified and updated to provide reports. The database currently provides data on birth admission, follow-up outpatient screening and audiological diagnostic reports. However, challenges remain with generating integrated reports necessary for follow-up and tracking of infants referred for additional screening or audiological evaluation.
92% (1606 of 1755) of newborns were screened in calendar year 2009.
38 were referred for additional screening and audiological evaluation and diagnosis. None were identified with permanent hearing loss.
Increased communication between the Nursery and MCH -- results of hearing screen being placed on the newborn discharge summary and on the It's a boy/ It's a girl card has been effective in catching newborns that initially failed a hearing screen and need to be re-tested earlier during 2 week postnatal visit rather than later when they demonstrate language problems. Those that do not pass on repeat testing are immediately referred to Audiologist or ENT for full evaluation.

The program is funded 100% by the Title V Program.
Updated OAE testing equipment was received on both islands. This increased the ability for more precise and accurate testing results.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide otoacoustic emissions screening for all newborns before hospital discharge or by one month of age.			X	
2. Provide hearing screening technicians on a daily basis.			X	
3. Provide literature on newborn hearing screening for prenatal providers.			X	
4. Provide parent education literature on hearing screening.			X	X
5. Increase awareness about the benefits of newborn hearing screening and early identification of hearing loss.			X	X
6. Maintain integrated database into one system for data collection, tracking, reports and analysis.				X
7. Evaluate qualitative screening data to determine program efficiency in screening, identification of hearing loss and referral to early intervention services.				X
8. Ensure enrollment into early intervention services for newborns diagnosed with a hearing loss by 3 months of age.	X	X		
9.				
10.				

b. Current Activities

The program is funded by 100% by the Title V Program.
Training and evaluation for the screening technicians is on-going. On-site evaluations are done quarterly by the Territorial Audiologist to assess screening proficiency, communication / interaction with families; compliance with confidentiality rules and equipment care.
Continue to monitor and track infants identified with permanent hearing loss or impairment or have documented risk conditions for late onset of hearing loss.
Increased communication between the Nursery and MCH -- results of hearing screen being placed on the newborn discharge summary and on the It's a boy/ It's a girl card has been effective in identifying newborns who initially did not pass hearing screen and were able to be re-tested earlier during 2 week postnatal visit rather than later when they demonstrate language problems. Those that did not pass on repeat testing are immediately referred to the Audiologist for further testing and to ENT for full evaluation.

c. Plan for the Coming Year

Newborn hearing screening will continue at both hospitals.
Newborn Hearing Screening Technicians will provide assistance with follow-up for infants who need rescreening or referrals for audiological assessments.
Audiologists will provide follow-up for infants at-risk for late onset hearing loss.
Families of newborns identified with a hearing loss will be contacted by program staff to ensure follow-up and enrollment into early intervention by 6 months of age. Develop and implement referral and reporting mechanism to ensure enrollment into early intervention for each newborn diagnosed with a hearing loss.
Challenges still exist with gathering timely follow up data on infants referred for further diagnostic evaluation.
MCH Program will continue improving data quality, collection, tracking and reporting procedures

by evaluating ways to improve the existing database system.
Newborn hearing screening/follow-up rates will continue to be monitored on a monthly basis.
Increase awareness about the benefits of newborn hearing screening and early identification of hearing loss.
Plan and implement activities to assure achievement of HP 2010 Objective 28-11 - Increase the proportion of newborns who are screened for hearing loss by age 1 month, have audiologic evaluation by age 3 months, and are enrolled in appropriate intervention services by age 6 months (Developmental).

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	15	15	15	10	10
Annual Indicator	19.0	22.4	8.8	12.0	9.4
Numerator	6603	7785	2283	2728	2872
Denominator	34817	34817	25805	22697	30596
Data Source				VICS/ HealthPro	VICS / MCH clinics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	10	10	10	10	10

Notes - 2009
Denominator obtained from 2007 VI Community survey.
Numerator reflects number of children accessing services at MCH clinics in both districts with no source of insurance.
The Medical Assistance Program is not required to collect or report this data to CMS.

Notes - 2008
Denominator obtained from 2006 VICommunity survey.
Numerator reflects number of children accessing services at MCH clinics in both districts.
The Medical Assistance Program is not required to collect or report this data to CMS.

Notes - 2007
Data is not available from the Medical Assistance Program. Estimates are based on number of children without insurance who receive services at MCH clinics.

a. Last Year's Accomplishments
Children with Special Health Care Needs are disproportionately low-income, and because of this, they are at greater risk for being uninsured. Moreover, their needs for health care are greater.
MCH and CSHCN Programs refer families to MAP for eligibility determination.
There is no formal outreach program for the MAP or SCHIP Programs, since there are such limited resources to offer the families.

40% of children accessing care at MCH clinics were Medicaid certified. 52% were uninsured. 8% had private or group insurance.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Refer all families without health insurance to the Medical Assistance Program to determine eligibility.	X	X		X
2. Document and provide data for children (number and percent) without health insurance enrolled and receiving services.				X
3. Continue to provide care coordination services to children with special health care needs who access services.	X	X		
4. All children registered in the Title V program receive services regardless of insurance availability or ability to pay.	X	X		
5. Uninsured and underinsured children will continue to be provided financial assistance for access to diagnostic, specialty and sub-specialty care.	X	X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Families determined to be eligible for the Medical Assistance Program based on the federal income guidelines for poverty are referred to the MAP Program.
The actual number of eligible families with children is unknown as the MAP data system does not provide this information.

c. Plan for the Coming Year

All children registered in the Title V program receive services regardless of insurance availability or ability to pay.
Uninsured children will continue to be provided financial assistance for access to diagnostic, specialty and sub-specialty care based on need and availability of resources.
Families without health insurance will continue to be referred to the Medical Assistance Program to determine eligibility.
Continue to provide care coordination services to children with special health care needs who access services.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		10	10	10	10
Annual Indicator	12.6		4.4	11.8	13.6
Numerator	277		186	276	397

Denominator	2198		4261	2339	2923
Data Source				WIC/PedNSS	WIC/PedNSS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	10	10	10	10	10

Notes - 2009
Data not available from WIC Program at the time of submission for this measure.

Notes - 2007
Data not available from the WIC at the time of this report.

a. Last Year's Accomplishments
Implemented the new food packages according to Federal Program Regulations which were designed to help fight the trend of increased obesity and chronic disease incidence in the nation. Most of the year's activities focused around the implementation of these new food packages, as major programmatic revisions had to be made to incorporate the foods offered in policies and procedures as well as in the WIC IT system.
New foods offered include whole grain bread, fruits and vegetables, and soy beverage and tofu for those participants who are milk intolerant. All children and women participants except 1year olds had their milk option changed to reduced or non fat milk.
Numerous staff and vendor trainings about the new food packages occurred throughout the year. Nutritionists developed participant nutrition education materials to educate participants about the new food packages, about using more fruits and vegetables in their diets and changing to reduced fat milk.
WIC staff continued to help participants identify correct portion sizes through nutrition education hands on activities such as a session held in one clinic. Clients had to identify the standard serving size of 4 foods displayed. eceive a prize if the got 3 out of 4 correct. This client centered approach embraces the new WIC Value Enhanced Nutrition Assessment (VENA) philosophy which focuses on desired health outcomes rather than deficiencies. It encourages the use of methods that are participant led.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to provide participants education on basic nutrition and importance of physical activity.	X		X	
2. Continue to implement an intervention strategy that provides nutrition education to at-risk participants	X			X
3. Continue current year activities.		X	X	X
4. Provide nutrition assessment, counseling and education at certification.	X		X	
5.				
6.				
7.				
8.				

9.				
10.				

b. Current Activities
Clinic staff continue to provide nutrition education activities for WIC participants to assist them to prepare healthy meals for their families and also to keep them in good health.
WIC participants receive nutrition education according to risk and program policies and procedures that would enable them to make informed decisions about their nutritional health.

c. Plan for the Coming Year
Ensure that WIC clients are certified and receive nutrition services according to established guidelines.
Continue revision of policies and procedures so that they are compatible with WIC on the Web (WOW) functions and VENA.
Continue to train staff and implement changes necessary for the Value Enhanced Nutrition Assessment (VENA) requirements in order to continue to provide optimal nutrition services for WIC clients.
WIC Program staff will continue to provide participants education on basic nutrition and importance of physical activity.
Continues to provide specialized food packages based on individual needs.
Provide food preparation classes for participants.
Implement a plan to address pediatric obesity prevention and management.
WIC participants will continue to receive nutrition assessment, counseling and education at certification. Nutrition education is provided individually and in interactive group sessions.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		1	1	1	1
Annual Indicator	1.5	1.8	1.8	0.5	0.0
Numerator	25	32	32	10	0
Denominator	1686	1751	1771	1844	1755
Data Source				Vital Records	NBS Database / Vital Records & Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	1	1	1	1	1

Notes - 2009
Denominator obtained from Newborn Screening Database - live birth admissions.

Data for numerator is not availabe at the time of submission for this measure from the Office for Vital Records & Statistics.

Notes - 2008
Data obtained from Vital Records and Statistics. information reported on certificate of live birth.

a. Last Year's Accomplishments
Data reported from Vital Statistics for CY 2008 shows that 0.5% (10 of 1844) of pregnant women reported smoking in the last three months of pregnancy.

Data for this measure not available for CY 2009.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Encourage cessation of tobacco, alcohol and other drug use during pregnancy.		X		
2. Continue to provide risk screening and encourage first trimester enrollment into prenatal care.	X	X		
3. Provide care coordination for women at risk for poor birth outcomes through outreach activities to ensure access to prenatal care.	X	X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Prenatal care providers in the MCH and Community Health Clinics promote tobacco cessation. Prenatal clinic staff provide education on risk behaviors during pregnancy to all prenatal women. This includes the impact of tobacco on fetal brain development and the increased risk of preterm birth and poor birth outcomes.
Cessation guides and literature are provided. Referrals are made to the Tobacco Prevention and Cessation Program.

c. Plan for the Coming Year
Tobacco and other drug use during pregnancy is proven to cause poor pregnancy outcomes - infant mortality, prematurity and very low birth weight.
Tobacco cessation will lead to prevention of long term health complications and second hand smoke exposure to infants and children. Encourage cessation of tobacco, alcohol and other drug use during pregnancy. Provide clients with education, informational materials and referrals to encourage and assist with smoking cessation.
Continue to provide risk screening and encourage first trimester enrollment into prenatal care.
In collaboration with VIPI, provide care coordination for women at risk for poor birth outcomes through outreach activities to ensure access to prenatal care.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	5	2	2	2	2
Annual Indicator	0.0	0.0	0.0	0.0	0.0
Numerator	0	0	0	0	0
Denominator	8821	8821	8751	8534	8138
Data Source				Vital Records	VICS / Vital Records & Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	1	1	1	1	1

Notes - 2009
Denominator obtained from VI Community Survey.

Data for numerator not available from the Office for Vital Records & Statistics as the time of submission for this measure.

a. Last Year's Accomplishments
The rates for youth suicide in the VI are unknown. Official data is not available from the Bureau of Health Statistics. There are no other known sources of data for this measure.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Address the need for community awareness and education on youth suicide prevention.				X
2. Develop and implement a referral plan to improve opportunities for children and adolescents to receive assessment, evaluation and treatment.	X	X		X
3. Collaborate with appropriate agencies to educate the public and professionals about depression and youth suicide.		X		X
4.				
5.				
6.				
7.				

8.				
9.				
10.				

b. Current Activities

Lutheran Social Services has established a hot-line (TEEN-LINE). This line provides confidential, free phone counseling and encourages teens to be aware of suicide symptoms in others they know or themselves.

DOH Children's Mental Health Services provide screening and treatment on a limited basis due to a lack of providers.

According to data reported for FY 2009, this division provided services to 110 children ages 1 -- 17. These services included individual, family and group therapy; monitoring of medication and psychiatric evaluations. The Division continues to provide comprehensive community-based mental health to children, adolescents and adults in the Frederiksted catchment area. The Child & Family Therapist provided much needed services to the substance abuse and child and adolescent populations.

c. Plan for the Coming Year

Conduct a follow-up survey to those programs which self-identify as serving MCH populations and assessing social/emotional health in MCH populations. More specifically, the survey will identify (a) protocols, standards and guidelines for screening and referral; (b) screening tools currently being used to assess social/emotional health; (c) training provided to develop skills; (d) data sources and types of data collected on screening and referrals; (e) needs for services by population group; and (f) partners/ collaborators.

While there are services in the community available to children and youth who experience any of these issues, the information may not be readily available to them at the time of need.

Coordinated efforts need to be undertaken to address the need for community awareness and education on youth suicide prevention. A plan to improve opportunities for children and adolescents to receive assessment, evaluation and treatment must be developed and implemented.

Collaborate with appropriate agencies to educate the public and professionals about depression and youth suicide through educational conferences, radio, newspaper and television programs.

Assure information and referral sources for families of children requiring mental health assessment, management and treatment are disseminated to schools, community & faith-based organizations and programs or agencies where adolescents congregate, e.g. after school youth activities.

Though suicide is the 11th leading cause of death in the US, it is not proven to be among the leading causes of death in adolescents or a priority area of concern in the VI. Valid, accurate data is not available to document suicide attempts or completion. Increasing awareness through health education and promotional activities on mental health, suicide prevention and identification of at-risk children needs to be a collaborative effort with public and private agencies.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	0	0	0	0	0
Annual Indicator	0.0	0.0	0.0	0.0	0.0
Numerator	0	0	0	0	0
Denominator	1676	1513	1771	1844	1755

Data Source				Vital Records	NBS Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes		
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	0	0	0	0	0

Notes - 2009
This measure does not apply to VI. There is a Level II Neonatal ICU. There are no facilities for high-risk deliveries and neonates.

Denominator obtained from NBS Program - live birth admissions during calendar year 2009.

Notes - 2007
This measure does not apply to VI. There is a Level II Neonatal ICU. There are no facilities for high-risk deliveries and neonates.

a. Last Year's Accomplishments
There are no Level III facilities in the Virgin Islands. This NPM is not applicable.
A Level II nursery exists on St. Thomas and St. Croix, which are both staffed with neonatologists Newborns requiring neurosurgery or cardiac surgery may be transferred to Puerto Rico or Florida. Coordination and communication among health care and related systems were maximized to increase service utilization, and minimize gaps and duplication. The infrastructure for provision of services was strengthened in order to make a meaningful impact on the health status of women.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. There are no Level III facilities in the Virgin Islands.				
2. Prenatal clinic staff will perform appropriate risk assessment and encourage women to seek care for signs of early labor.	X	X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
There are no plans to open a Level III nursery in the Virgin Islands. Present arrangements will be continued.
Prenatal clinic staff will perform appropriate risk assessment and encourage women to seek care for signs of early labor.

c. Plan for the Coming Year
There are no plans to open a Level III nursery in the Virgin Islands. Present arrangements for maternal transport will be continued on a case by case basis.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	65	65	65	65	70
Annual Indicator	64.2	66.2	62.6	36.4	36.9
Numerator	1083	1167	1109	672	647
Denominator	1686	1763	1771	1844	1755
Data Source				Vital Records	NBS Program/Prenatal clinics reports
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	70	70	75	75	75

Notes - 2009
The data for calendar year 2009 from the Office of Vital Records and Statsitics is not available at the time of submission for this measure.

Denominator reflects live births admissions reported by the NBS Program Database.

Numerator reflects number of prenatal clients accessing care at DOH Community Health, MCH Prenatal and 330 FQHC's (2) during calendar year 2009.

Notes - 2008
The data for calendar year 2008 from the Office of Vital Records and Statsitics is incomplete, and only reflects 33% of the records for birth certificates which have been evaluated and edited as of reporting date.

Final data for this numerator is anticipated to be available by the end of October 2009.

Notes - 2007
Numerator reflects data available for the first three quarters of CY 2007.

Denominator reflects number of live births admissions.

a. Last Year's Accomplishments

The MCH Unit provides primary and preventive care to pregnant women, mothers and infants. Data estimates for the MCH-St. Croix and the FQHC's prenatal clinics show that 44.7% of prenatal patients (647 of 1446) enrolled in prenatal care in the first trimester in CY 2009. In comparison, preliminary data for the same period in calendar year 2008 from the Office of Vital Records and Statistics show that 36.4% % of women (672 of 1844) accessed care in the first trimester. This data is incomplete. 2009 calendar year data is not available.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue partnerships with programs that encourage early enrollment in early prenatal care.		X	X	X
2. Increase healthy birth outcomes through promotion of healthy behaviors and lifestyles.		X		
3. Plan and implement activities to meet HP 2010 Objective 16.6 - Increase the proportion of pregnant women who receive early and adequate prenatal care (80%).	X	X		X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Outreach activities are on-going to high or at-risk pregnant women in low-income, underserved communities by VI Perinatal, Inc. (VIPI) outreach staff and case managers who encourage women to seek care early and continuous care to guarantee the best possible outcome for delivery.

An on-going awareness and social marketing campaign by VIPI also stresses the importance of early and adequate prenatal care in preventing preterm births and poor birth outcomes.

c. Plan for the Coming Year

Continue partnerships with programs that encourage early enrollment in early prenatal care, i.e. Family Planning, VIPI, through outreach, education and awareness activities.

Prenatal clinics will perform appropriate risk assessment and encourage women to seek care for signs of early labor.

Increase healthy birth outcomes through promotion of healthy behaviors and lifestyles.

Plan and implement activities to meet HP 2010 Objective 16.6 - Increase the proportion of pregnant women who receive early and adequate prenatal care (80%).

D. State Performance Measures

State Performance Measure 1: *The percent of CSHCN clients who access family support services.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		50	50	55	55
Annual Indicator	50.0	43.5	30.0	6.5	20.0
Numerator	574	454	375	100	301
Denominator	1149	1044	1248	1530	1505
Data Source				MCH Program	MCH Program
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	55	60	60	55	

Notes - 2009
Data reflects information from St. Thomas/ St. John district only.

Notes - 2008
Data reflects information from St. Thomas/ St. John district only.

Notes - 2007
Numerator reflects # of families using services such as VI FIND (Family Information Network on Disabilities).

a. Last Year's Accomplishments
Case management and care coordination services, family counseling, respite care are a few of the services needed by families of children with special health care needs. While these may be available from several sources families may have challenges accessing them. Efforts to identify appropriate support and referral services for families with CSHCN and to provide up to date information for families relative to community resources available.
A directory of community-based services and outreach programs was compiled for use by families and providers. This was done in response to a need for a source of updated information in one document.
Efforts to strengthen relationships with other community providers to coordinate services, reduce duplication of services, determine unmet needs, and assure that the children requiring services receive them continued. A system for tracking referrals was instituted by program nurses in the St. Thomas District.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Continue efforts to identify appropriate support and referral services for families with CSHCN		X		X
2. Provide current information for families relative to available community resources.	X	X		
3. Provide families with linkages to community organizations and parent advocacy groups		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Provide families with linkages to community organizations and parent advocacy groups.
The program provided information and referral services to appropriate agencies based on families identified needs.

c. Plan for the Coming Year
Continue to identify information and support needs of families through a referral network of community and faith based organizations and programs.
Continue to partner with parent groups, public and private agencies and service providers to build resources and increase capacity to meet family needs.
The program has existing collaborative partnerships with community based organizations that provide services to children and families. These include but are not limited to advocacy groups, legal services, resource and training centers, child care providers, family support and faith based organizations.
The V.I. Alliance for Primary Care and the MCH Advisory Council, which includes members from these organizations are the focal point for developing and maintaining these community collaboratives to promote partnerships between families and service providers.
Continue to assist families in accessing services based on identified needs.
Utilize a referral / feedback system for tracking purposes and to determine outcomes of services provided.
Continue efforts to implement family-centered, culturally competent, and community-based systems of referral and care and to simplify access to these systems for families.
Periodically evaluate referral system to assure that it is consistent with the Title V vision to integrate and strengthen community-based programs into a system of services that is more accessible and responsive to families and communities.
Establish data collection mechanism to monitor, track and determine positive outcomes and successful achievement of HP 2010 Objective16-23 (Developmental) Increase the proportion of Territories and States that have service systems for children with special health care needs.

State Performance Measure 2: *Increase the percent of CSHCN families' participation in transition planning to at least 50%.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		25	35	40	45
Annual Indicator	20.5	2.6	1.2	8.9	0.3
Numerator	235	27	15	136	5
Denominator	1149	1044	1248	1530	1505
Data Source				MCH Program	MCH Program
Is the Data Provisional or Final?				Provisional	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	50	50	50	50	

Notes - 2009
Data reflects information from St. Thomas/ St. John district only.

Notes - 2008
Data reflects information from the St. Thomas/ St. John district only.

a. Last Year's Accomplishments

Many children and adolescents with special health care needs are unable to maintain placement in higher education, sustain employment, or live independently and are less likely than their non-disabled peers to complete high school, attend college or to be employed. Their health care is generally managed by parents or guardians and they may have little experience managing their own health care, or understanding their medical conditions. Families may be unaware of the programs and resources that can assist. Pediatric and adult health care providers often do not communicate or collaborate to successfully transfer care from one to another.

The program utilized a plan for youth and adolescents with special health care needs transitioning to adulthood. The plan is based on the Healthy and Ready to Work model which facilitates the integration of service systems to address the health issues of this population. Public health nurses ensured appropriate referrals for all adolescent and young adult clients to the appropriate agencies for health/school/work transition. 5 young adults were successfully transitioned this fiscal year.

The plan supports skill-building opportunities for youth and their families. It supports their involvement as decision makers in their health care, education and employment.

Improvement in transition activities related to increasing family /youth advocacy and connecting families/youth with information regarding community / university resources for educational and vocational planning is needed to achieve the goal of 50%.

Collaboration and coordination continued with several agencies to assure effective transition - Departments of Education, Vocational Education; Department of Human Services, Vocational Rehabilitation; Department of Labor, Job Training and Placement; Community Health and 330 Centers; community based organizations, i.e. V.I. Resource Center for the Disabled, University of the Virgin Islands Center for Excellence on Developmental Disabilities, Virgin Islands Assistive Technology Foundation, Inc., V.I. Center for Independent Living, and V.I. Family Information Network on Disabilities.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Encourage adolescents and their families to participate in transition planning.	X	X		
2. Utilize a transition checklist tool based on the Healthy and Ready to Work model.		X		
3. Continue to work on the transition tool and work with youth to address medical transition issues.	X	X		
4. Assure comprehensive and timely transition to adult health care and employment.	X		X	
5. Continue collaboration with appropriate agencies to ensure transition to adulthood and independence.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Encourage adolescents and their families to participate in transition planning.

c. Plan for the Coming Year

Ensure that adolescents with special health care needs have a transition plan as part of care coordination.
Implement a plan to assure healthy and effective transition to adulthood including employment, healthcare and independent living activities.
Develop and implement a transition manual.
Continue to utilize the transition checklist based on the Healthy and Ready to Work model.
Actively seek involvement of youth in transition related training activities, i.e., workshops.
Continue collaboration with appropriate agencies to ensure transition to adulthood and independence.
Educate adult health care providers on the needs of transitioning youth and their families.

State Performance Measure 3: *The percent of CSHCN who receive coordinated, comprehensive care in a medical home.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		55	55	55	60
Annual Indicator	50.6	10.8	38.1	54.6	39.9
Numerator	581	113	475	835	600
Denominator	1149	1044	1248	1530	1505
Data Source				MCH Program	MCH Program
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	65	65	65	65	

Notes - 2009
MCH Clinics in both districts continue to provide medical home as defined by the AAP.

Notes - 2008
Data for this measure was obtained from the VI DOH HealthPro database.

a. Last Year's Accomplishments
The Title V program is considered the medical home as defined by the American Academy of Pediatrics, for a large percent of the CSHCN population.
For many VI families, the medical home is where a child with special health care needs and his/her family can count on having medical care coordinated, by a public health nurse or service coodinator with involvement of the pediatrician. These nurses and families work together and access all of the medical and non-medical services needed to help CSHCN achieve their potential. Factors that contribute to this are increasing numbers of underinsured and uninsured families; welfare to work policies for single head of household families that offer low paying jobs with little or no medical insurance benefits or paid days off; and an overall poverty rate of 46.7% for children under 18 years in the territory. In addition, private pediatricians and other primary care providers routinely refer families to the program for access to specialty care not otherwise available.
The program continued efforts to assure a medical home for all children with special health needs.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue efforts to assure a medical home for all children with special health needs.		X		X
2. Provide access to comprehensive, coordinated medical health care services for CSHCN.		X		X
3. Continue to incorporate and promote the medical home concept in planning efforts and program services.				X
4. Continue to provide education to parents on the importance of the medical home.	X	X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Provide access to comprehensive, coordinated medical health care services for CSHCN.
Continue to work with primary care, allied health and other providers on ensuring continuity of care.
Public health nurses continue to provide leadership in case management and coordination of specialty clinics.
Home visits, or visits in the natural environment to provide services needed for CSHCN are provided by nurses and allied health staff.

c. Plan for the Coming Year

Continue to incorporate and promote the medical home concept in planning efforts of program and services.
Increase the number of children and youth receiving comprehensive care through a medical home.
Continue to provide education to parents on the importance of having a medical home.
Provide additional staff training and development needed for the provision of care coordination including: medical home, transition of CSHCN, cultural competence, and community-based care.

State Performance Measure 4: *The percent of teen mothers who received parenting skills training.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		35	30	30	35
Annual Indicator	33.5	22.4	36.2	52.6	0.0
Numerator	68	41	55	120	0
Denominator	203	183	152	228	119
Data Source				Community based organizations	Community based organizations/DHS
Is the Data Provisional or Final?				Final	Provisional

	2010	2011	2012	2013	2014
Annual Performance Objective	35	35	40	40	

Notes - 2009
This information is based on the 2008 teenage birth rate vital records . The denominator is the estimated number of births for the population aged 15-19 for 2009. Data is incomplete.

Numerator is based on information provided by community-based organizations that provide parenting classes.

Notes - 2008
This information is based on the 2007 teenage birth rate vital records . The denominator is the actual number of births for the population aged 15-19 for 2007. 2008 data is incomplete.
Numerator is based on information provided by community-based organizations that provide parenting classes.

Notes - 2007
Numerator obtained from agencies providing parenting skills training such as Family Resource Center, Lutheran Social Services and Childworth.
Denominator reflects preliminary data obtained from DOH - Bureau of Health Statistics.

a. Last Year's Accomplishments
Teen parenting classes are offered by various non-profit organizations throughout the Territory. Organizations such as the Village and Beyond Vision, seek to empower the youth through the improvement of both social and practical skills. The Department of Human Services provides teen parenting classes in coordination with Family Resource Center.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Establish partnerships with health educators, guidance counselors or individuals from other community based organizations that provide family support services.		X		X
2. Develop and implement a referral system with CBO's that provide parenting skills/education programs.		X		
3. Obtain and review criteria for evidence-based family support and parenting education programs.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Parent University is an initiative of the Department of Education to educate parents on how to help their children to succeed in school; how to use the same type of technology their children use; how to cope with the various challenges their children face daily--especially gangs and violence; how to keep children safe on the internet; how to advocate for their children in the school setting and much more. Parents develop various skills, understand how to become partners with their children's school, and earn certificates at the end of a four week session. This year 2010, St. Croix had two graduating classes; the last on May 23, 2010 graduated 201

students. St. Thomas/St. John's first class on February 17, 2010 had 104 parents graduating. The classes are open to all parents of all ages and backgrounds. The sessions are a combination of classes and workshops. Some of the sessions were held in Spanish as well as English. Transportation, child care and refreshments were provided at each session. VIUCEDD (Virgin Island University Center for Excellence in Developmental Disabilities) and VIOSEP (VI Office for Special Education) are working together on several projects. One is to implement a district wide Positive Behavioral Program. A parent empowerment project through a series of monthly workshops and an annual conference is offered. System --wide issues that affect children from Early Childhood Education through High School are being addressed.

c. Plan for the Coming Year

Continue collaborations with health educators, guidance counselors or individuals from other community-based organizations who provide family support services. Strenghten referral and feedback system.

Obtain and review criteria for evidence-based family support and parenting education programs.

State Performance Measure 5: *Percent of infants identified with hearing loss who are receiving appropriate intervention services by age 6 months.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		60	60	70	80
Annual Indicator					
Numerator	3	3	2	2	3
Denominator	22	70	217	126	41
Data Source				NHS Program	NHS Program
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	90	95	95	98	

Notes - 2009

Data reported from Audiologists (2) for calendar year 2009.

Notes - 2008

The data for the denominator is obtained from infants who did not pass initial hearing screening in the birth admission and were referred to the Audiologist for follow-up testing.

The numerator indicates the number identified with permanent hearing loss and referred to early intervention services.

a. Last Year's Accomplishments

Healthy People 2010 Revised Objective 28-11: Increase the proportion of newborns who are screened for hearing loss by age 1 month, have audiologic evaluation by age 3 months, and are enrolled in appropriate intervention services by age 6 month was used as the benchmark for continued implementation of hearing screening.

Appropriate and timely early intervention services before six months of age promote optimal language, cognitive, and social development

Newborn screening technicians are available on a daily basis including weekends and holidays. Updated and high technology OAE equipment was purchased for both islands. Screening rate before hospital discharge was 92% in calendar year 2009.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Audiologists will perform diagnostic evaluation by 3 months of age to confirm permanent hearing loss (PHL).	X		X	
2. Refer infants identified with permanent hearing loss for early intervention services before six months of age	X	X	X	
3. Continue to assist families in obtaining audiological evaluations.		X		
4. Provide literature on permanent hearing loss to parents and providers.		X		X
5. Continue to monitor and track infants identified with PHL.	X	X		
6. Obtain technical assistance and training to improve data collection, analysis and reporting skills.				X
7.				
8.				
9.				
10.				

b. Current Activities

Training and evaluation for the screening technicians is on-going. On-site evaluations are done quarterly by the Territorial Audiologist to assess screening proficiency, communication / interaction with families; compliance with confidentiality rules and equipment care.
Continue to monitor and track infants identified with permanent hearing loss or impairment or have documented risk conditions for late onset of hearing loss.
Increased communication between the Nursery and MCH -- results of hearing screen being placed on the newborn discharge summary and on the It's a boy/ It's a girl card has been effective in catching newborns who initially did not pass hearing screen and were able to be re-tested earlier during 2 week postnatal visit rather than later when they demonstrate language problems. Those that did not pass on repeat testing are immediately referred to the Audiologist for further testing and to ENT for full evaluation.

c. Plan for the Coming Year

Audiologists will perform diagnostic evaluation by 3 months of age to confirm permanent hearing loss (PHL).
Continue to assist families in scheduling audiological evaluations.
The program continues to provide brochures explaining newborn hearing screening and explaining what to expect when a baby does not pass the hospital screening.
Provide literature on permanent hearing loss to parents and providers.
Refer infants identified with permanent hearing loss for early intervention services before six months of age to ensure appropriate and timely services to promote optimal language, cognitive, and social development.
Continue to monitor and track infants identified with PHL- amplification, and early intervention enrollment.
Obtain technical assistance and training to improve staff data collection, analysis and reporting skills.
Plan and implement activities to assure achievement of HP 2010 Objective 28-11 - Increase the proportion of newborns who are screened for hearing loss by age 1 month, have audiologic evaluation by age 3 months, and are enrolled in appropriate intervention services by age 6 months.
The MCH & CSHCN Program will continue to refer infants with permanent hearing loss for EI services, and will monitor and track diagnostic audiological evaluations, confirmed hearing status,

amplification, and EI enrollment status.

State Performance Measure 6: *Increase the rate of pregnant women who enroll in prenatal care in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		600	600	650	650
Annual Indicator	642.3	661.9	626.2	364.4	368.7
Numerator	1083	1167	1109	672	647
Denominator	1686	1763	1771	1844	1755
Data Source				Vital Statistics	NBS Program/Prenatal clinics reports
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	700	700	700	750	

Notes - 2009
The data for calendar year 2009 from the Office of Vital Records and Statsitics is not available at the time of submission for this measure.

Denominator reflects live births admissions reported by the NBS Program Database.

Numerator reflects number of prenatal clients accessing care at DOH Community Health, MCH Prenatal and 330 FQHC's (2) during calendar year 2009.

Notes - 2008
The data for calendar year 2008 from the Office of Vital Records and Statsitics is incomplete, and only reflects 33% of the records for birth certificates which have been evaluated and edited.

Final data for this numerator is anticipated to be available by the end of October 2009.

a. Last Year's Accomplishments
The Healthy People 2010 Revised Objective 16-16: Increase the proportion of pregnant women who receive early and adequate perinatal care beginning in the first trimester of pregnancy was used as the benchmark for promotion of early enrollment in prenatal care. The target rate of 600 per 1000 women was the goal set for this year. Based on data from the DOH Vital Records & Statistics in CY 2008, 36.4% of women were enrolled in the first trimester. 2009 data is not available.
Prenatal care includes three major components: risk assessment, treatment for medical conditions or risk reduction, and education. The American College of Obstetricians and Gynecologists (ACOG) recommends that women receive at least 13 prenatal visits during a full-term pregnancy.
Prenatal care is more likely to be effective and produce better outcomes if care begins early in pregnancy and continues as recommended throughout the pregnancy.
The MCH Unit provides primary and preventive care to pregnant women, mothers and infants. Women have access to comprehensive reproductive health care and a referral mechanism to the Family Planning Program.

A major focus of the V.I. Perinatal Inc., is to enroll women in prenatal care early.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to provide access to prenatal care and encourage women to enroll early.	X	X		
2. Continue partnerships with programs that encourage early enrollment in prenatal care		X		X
3. Increase healthy birth outcomes through promotion of healthy behaviors and lifestyles	X		X	
4. Pregnant women will receive appropriate number of prenatal care visits that begins in the first trimester.	X			
5. The Family Planning program will continue to provide pregnancy testing with early referral of women to prenatal care.	X		X	
6. Promote activities that reflect HP 2010 Revised Objective 16-16: Increase the proportion of pregnant women who receive early and adequate perinatal care beginning in the first trimester of pregnancy		X	X	X
7.				
8.				
9.				
10.				

b. Current Activities

Prenatal care is more likely to be effective if women begin receiving care early in pregnancy. Continue to provide access to prenatal care and encourage women to enroll early. Women beginning care in the third trimester and those receiving no prenatal care are at increased risk for poor pregnancy / birth outcomes.

The MCH Program continues to provide care coordination, health education and counseling to pregnant women with health and social risk factors associated with low birth weight and very low birth weight infants in efforts to improve prenatal and birth outcomes.

Referrals are made to the WIC Program to supplement diets of pregnant women, who may be nutritionally at risk based on medical and nutrition assessment and federal poverty guidelines.

c. Plan for the Coming Year

Continue partnerships with programs that encourage early enrollment in early prenatal care, i.e. Family Planning, VIPI, through outreach, education and awareness activities.

Prenatal clinics will perform appropriate risk assessment and encourage women to seek care for signs of early labor.

Increase healthy birth outcomes through promotion of healthy behaviors and lifestyles.

Pregnant women will receive appropriate number of prenatal care that begins in the first trimester.

The Title V MCH/CSHCN Program Director will continue to serve on the VIPI Board of Directors and participate in activities to reestablish Fetal Infant Mortality Review Committee. The collaborative efforts of community partners will continue to sustain the VIPI's initiatives to address health disparities, access to quality care and improvement in the overall health of the community.

Continue to provide outreach in populations where perinatal illness and disability rates and mortality rates are highest and who are most likely to have low incomes.

The Family Planning program will continue to provide pregnancy testing with early referral of

women to prenatal care.
Promote postpartum follow-up and family planning to decrease unplanned pregnancies, enroll women in care and encourage pregnant women to enroll early prenatal care.

State Performance Measure 7: *The rate per 10000 of hospitalizations due to asthma in children 0-14.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		5	5	5	5
Annual Indicator	5.7	5.0	2.0	2.9	3.3
Numerator	158	130	52	66	74
Denominator	27671	25996	25805	22697	22458
Data Source				RLS & JFL Hospitals	RLS & JFL Hospitals
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	5	5	5	5	

Notes - 2009
Data from both island hospitals reflects in-patient admissions only. Average length of stay was 1.5 days.

Notes - 2008
Data from both island hospitals reflects in-patient admissions only. Average length of stay was 1.5 days.

Notes - 2007
Numerator reflects in-patient admissions to hospitals in both districts. Due to availability of pulse oximetry and stabilizing nebulizer/aerosol treatments in both MCH clinics, the number of children seen in emergency departments has dropped significantly.

a. Last Year's Accomplishments
With the use of nebulizer treatments and administration of first dose of steroids in the clinic, with careful follow-up, the number of ER visits and hospitalizations have decreased in this population. With continued parental and child education and use of preventative medications, the number of asthma exacerbations per year has also decreased.
Asthma education and prevention efforts were held in collaboration with organizations such as the American Lung Association (ALA), VI Chapter.
Provide asthma education resources to families, children and school personnel.
Encourage utilization of asthma plans obtained from ALA , National Institutes of Health and New York State DOH by program staff.
The MCH Program utilizes the New York State Asthma action plan for parents and clinical management materials for the nurses and pediatricians to use in their education of parents.
School Health activities by the VI Chapter of the ALA and DOH Office of Minority Health included: in-school care and management, and health education (child self-care education, asthma management education) using the American Lung Association's Open Airways for Schools curriculum and partnership promotion for asthma friendly school environments using the federal Environmental Protection Agency's Tools for Schools. Populations served included elementary and junior high schools and school staff.
Infrastructure-building services are ongoing in many DOH programs and include supporting education and prevention initiatives through the provision of expertise, technical assistance, and

guidance in childhood asthma management and care, and provision of asthma resources to community health care providers, schools, day care facilities, children and families.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide asthma education resources to families, children and school personnel.				X
2. Provide on-going and continuous asthma education and management to families with a focus on self-management.	X	X		
3. Continue to promote use of asthma plans to families.	X	X		
4. Design, establish and implement an asthma surveillance system to obtain accurate data collection for analysis to monitor quality of care and outcomes.				X
5. Promote activities to achieve HP2010 Objective 24 – Promote respiratory health through better prevention, detection, treatment and education.				X
6. Provide awareness and education programs for child care providers and early childhood school personnel.				X
7. Provide guidance in childhood asthma management and care via the provision of asthma resources to community health care providers, schools, day care facilities, children and families.				X
8.				
9.				
10.				

b. Current Activities

Reductions in frequent hospitalization or emergency department admissions are an indicator of the health care system's success in helping families and children manage and control asthma.
In addition to the above, education on the proper use on MDI's and nebulizer treatment has been effective in children being treated appropriately. The use of handouts on asthma and asthma care has also been effective in improving parental awareness and appropriate treatment.
Implement existing asthma education plan to provide on-going and continuous asthma education and management to families with a focus on self-management.
Monitor outcomes of asthma education and management.
Provide asthma materials and resources on environmental triggers to primary care providers, schools and other interested individuals.
Collaboration with the American Lung Association (ALA), VI Chapter should be strengthened and new partnerships developed. This would provide opportunities for public health, schools and community organizations to work together to develop and implement an asthma plan including an evaluation and surveillance system.

c. Plan for the Coming Year

Promote activities to achieve HP2010 Objective 24 -- Promote respiratory health through better prevention, detection, treatment and education efforts.
Revision of the asthma care protocol.
Establishing an asthma clinic in which intensive instruction and health care management will occur.
Re-designing a health care plan for both parents and the school for each patient with asthma in

accordance for the standards of the NIH -- NHLBI.
Education of the school nurses about asthma and the updated guidelines for management and treatment.
Institution of peak flow meters in the clinics and at home for parents to be able to implement the appropriate treatment.
Provide awareness and education programs for child care providers and early childhood school personnel.
Design, establish and implement an asthma surveillance system to obtain accurate data collection for analysis to monitor quality of care and outcomes.
Promote awareness and prevention of asthma issues in young children through the promotion of Bright Futures guidelines as the standard for well-child care, and the promotion of medical home for all children.
Utilize trained child care health consultants who are also public health nurses in the Title V Program and are knowledgeable about asthma recognition and treatment; to train and assist child care providers to recognize, cope with, and prevent asthma, and to work with parents to reduce environmental triggers in the home and external environments to the extent possible.
Promote childhood asthma education and prevention activities for children and their families, and provide resources to assist families with asthma management skills to reduce hospitalizations.
Reductions in re-hospitalization are an indicator of the health care system's success in helping families and children manage and control asthma. Through a number of DOH programs, we provide guidance in childhood asthma management and care via the provision of asthma resources to community health care providers, schools, day care facilities, children and families.

E. Health Status Indicators

Introduction

The on-going challenges faced by the program in acquiring variable population-based data to address the
respective health status indicators continued throughout this program year.
The data system of the Medical Assistance Program (MAP) does not have the functionality to provide the data needed to meet this indicator. An integrated data system is not in place. The MCH program remains without access or linkage to the Medical Assistance database or reports.
Challenges remain to acquiring valid, measurable data that effectively address these indicators, monitor and evaluate trends, clinical practice outcomes or perform program assessment and planning. Addressing these issues in the MCH population and developing strategies to improve services is dependent on an aggressive data driven system with qualified data management support which is non-existent. Therefore the ability to report on the status of these indicators remain unchanged.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	10.7	10.2	11.6	5.7	4.6
Numerator	181	180	205	106	80
Denominator	1686	1763	1771	1844	1755
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year,					

and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Calendar year 2009 data not available from Office of Vital Records & Statistics at time of submission.

Denominator obtained from Newborn Screening Database - number of live birth admissions.

Numerator obtained from DOH Community Health, MCH and 330 FQHC's (2) Prenatal Clinics.

Notes - 2008
Data obtained from DOH Vital Records & Statistics.

Narrative:
Low birth weight is one of the leading causes of infant mortality (LBW). LBW infants are also at higher risk for serious health complications, developmental delays, long-term disability, and poor school performance. Program staff in all public prenatal clinics encourage early and continuous prenatal care, provide education on adequate nutrition and wellness to support healthy pregnancies, and encourage risk reduction behaviors that contribute to poor birth outcomes. According to data estimates from the Bureau of Health Statistics for calendar year 2008, 5.6% of live births were below 2500 grams. This compares to 11.6% in the same period for 2007. Data is not yet available for calendar year 2009. This may be directly due to outreach activities to high or at-risk pregnant women in low-income, underserved communities by VI Perinatal, Inc. (VIPI) outreach staff and case managers who encourage women to seek care early and continuous care to guarantee the best possible outcome for delivery especially in low-income underserved communities. The population known to be below the federal poverty level is presumed eligible for Medical Assistance. However, the poverty threshold for annual allowable income to qualify for Medicaid in the VI is $9,500 for a family of five compared to the national average of $23,497 (Census Bureau 2004) for a family of five. This requirement causes difficulty for uninsured families to qualify for Medical Assistance and creates barriers to health care resources and services. These uninsured individuals are generally unable to afford health insurance premiums and therefore not as likely to seek early prenatal care which may contribute to poor birth outcomes. Trend data is not available. VI does not have a MCH Epidemiologist or biostatistician on staff.
From October 2008 to December 2009, VIPI served 71 high risk pregnant clients on St. Croix. 86.5% of enrollees had a normal birth weight, 13.5% had a birth outcome categorized as low birth weight. 44.4% had an educational level of 9-11 grade, 80% had an income of less than $10,000. 45% of the high risk pregnant clients were without insurance. Despite targeted outreach, 73.5% entered into prenatal care in the second or third trimester.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	9.4	9.4	10.6	4.3	0.0

Numerator	155	163	187	80	0
Denominator	1642	1740	1771	1844	1755
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Calendar year 2009 data not available from Office of Vital Records & Statistics at time of submission.

Denominator obtained from Newborn Screening Database - number of live birth admissions.

Notes - 2008
Data obtained from DOH Vital Records & Statistics.

Narrative:
The general category of low birth weight infants includes pre-term infants and infants with intrauterine growth retardation. Many risk factors have been identified for low birth weight babies including: both young and old maternal age, poverty, late prenatal care, smoking, substance abuse, and multiple births.
Data estimates from the Bureau of Health Statistics for calendar year 2008 shows that 4.2% of live singleton births were below 2500 grams. This compares to 10.6% in the same period for 2007. Data is not yet available for calendar year 2009. This apparent downward trend is not supported by valid, measurable data. This limits the capability to determine and evaluate contributing causes or strategies that have an effect on this otherwise positive outcome.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	2.0	1.6	1.4	0.4	0.2
Numerator	33	29	24	8	4
Denominator	1686	1763	1771	1844	1755
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
Calendar year 2009 data not available from Office of Vital Records & Statistics at time of submission.

Denominator obtained from Newborn Screening Database - number of live birth admissions.

Numerator obtained from DOH Community Health, MCH and 330 FQHC's (2) Prenatal Clinics.

Notes - 2008
Data obtained from DOH Vital Records & Statistics.

Narrative:
These very low birth weight (VLBW) infants are at highest risk of morbidity and mortality, long-term health complications and disabilities. Very low birth weight births are usually associated with pre-term birth. The primary risk factors for pre-terms births are prior preterm birth, prior spontaneous abortion, low pre-pregnancy weight, cigarette smoking, and multiple births. Data for calendar year 2008 shows that VLBW rate at 0.8% of all live births, compared to 1.4% in 2007. Birthweight, an important indicator of infant health is directly related to a baby's survival and continuing health. Babies born weighing less than 5.5 pounds (2,500 grams) are at high risk for developmental delays, both physical and cognitive. Low birthweight babies have been shown to account for more than half the costs incurred for all newborns. While the community bears some of these costs, families of these newborns are highly affected. These babies' longer and more costly hospital stays, and the degree of parental attention and time the babies may require, can destabilize family resources and impact or curtail a mother's employment outside the home. Timely, regular prenatal care for a pregnant mother is the most effective strategy for prevention of low birthweight for babies. (2009 VI Kids Count Data Book Community Foundation of the VI CFVI).

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	1.6	1.6	1.3	0.6	0.0
Numerator	27	28	23	11	0
Denominator	1642	1740	1771	1844	1755
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Calendar year 2009 data not available from Office of Vital Records & Statistics at time of submission.

Denominator obtained from Newborn Screening Database - number of live birth admissions.

Notes - 2008
Data obtained from DOH Vital Records & Statistics.

Narrative:

These very low birth weight (VLBW) infants are at highest risk of morbidity and mortality, long-term health complications and disabilities. Very low birth weight births are usually associated with pre-term birth. The primary risk factors for pre-terms births are prior preterm birth, prior spontaneous abortion, low pre-pregnancy weight, cigarette smoking, and multiple births. Data for calendar year 2008 shows that VLBW rate at 0.8% of all live births, compared to 1.4% in 2007. Birthweight, an important indicator of infant health is directly related to a baby's survival and continuing health. Babies born weighing less than 5.5 pounds (2,500 grams) are at high risk for developmental delays, both physical and cognitive. Low birthweight babies have been shown to account for more than half the costs incurred for all newborns. While the community bears some of these costs, families of these newborns are highly affected. These babies' longer and more costly hospital stays, and the degree of parental attention and time the babies may require, can destabilize family resources and impact or curtail a mother's employment outside the home. Timely, regular prenatal care for a pregnant mother is the most effective strategy for prevention of low birthweight for babies. (2009 VI Kids Count Data Book Community Foundation of the VI CFVI).

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	7.7	0.0	0.0	0.0	0.0
Numerator	2	0	0	0	0
Denominator	25996	24669	25805	22458	22458
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	Yes
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Calendar year 2009 data not available from Office of Vital Records & Statistics at time of submission.

Denominator obtained from 2007 VI Community Survey

Notes - 2008
Denominator obtained from USVI Community Survey 2007, Eastern Caribbean Center, University of the Virgin Islands.

Numerator obtained from VI DOH Vital Statistics.

Notes - 2007
Denominator obtained from 2005 VI Household Survey, UVI Eastern Caribbean Center;
Numerator obtained from DOH Bureau of Health Statistics.

Narrative:
VI Kids Count 2009 Data Book reports the child death rate was 50.7 per 100,000 children. This includes deaths from all causes including illness and injury.

Data obtained from the VI Office of Highway Safety - Traffic Safety Facts 2009 for these indicators. 1 fatality due to motor vehicle crash in children aged 14 years and younger was reported. The Division of EMS and hospital emergency departments do not collect or report data for these indicators.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	7.7	0.0	11.6	4.4	4.5
Numerator	2	0	3	1	1
Denominator	25996	24669	25805	22697	22458
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	Yes
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Denominator obtained from USVI Community Survey 2007, Eastern Caribbean Center, University of the Virgin Islands.

Numerator obtained from VI Office of Highway Safety.

Notes - 2008
Denominator obtained from USVI Community Survey 2006, Eastern Caribbean Center, University of the Virgin Islands.

Numerator obtained from VI Office of Highway Safety.

Notes - 2007
Denominator obtained from 2005 Household Survey, UVI Eastern Caribbean Center.
Numerator obtained from VI-Office for Highway Safety, Traffic Safety Facts, 2007.

Narrative:
VI Kids Count 2009 Data Book reports the child death rate was 50.7 per 100,000 children. This includes deaths from all causes including illness and injury.
Data obtained from the VI Office of Highway Safety - Traffic Safety Facts 2009 for these indicators. 1 fatality due to motor vehicle crash in children aged 14 years and younger was reported. The Division of EMS and hospital emergency departments do not collect or report data for these indicators.
Targeted injury prevention education is a component of health supervision and age appropriate anticipatory guidance provided by the MCH Program clinical staff -- physicians and nurses.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	7.0	0.0	13.7	35.5	14.2
Numerator	1	0	2	5	2
Denominator	14296	14296	14617	14085	14085
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Denominator obtained from USVI Community Survey 2007, Eastern Caribbean Center, University of the Virgin Islands.

Numerator obtained from VI Office of Highway Safety.

Notes - 2008
Denominator obtained from USVI Community Survey 2006, Eastern Caribbean Center, University of the Virgin Islands.

Numerator obtained from VI Office of Highway Safety.

Notes - 2007
Data obtained from VI-Office for Highway Safety, Traffic Safety Facts 2007.

Denominator obtained from 2005 VI Household Survey, UVI Eastern Caribbean Center.

Narrative:
There were 2 fatalities due to motor vehicle crashes reported in the 15 -- 24 years age group.

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	0.0	338.5	472.8	312.8	472.0
Numerator	0	88	122	71	106
Denominator	25996	25996	25805	22697	22458
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Denominator obtained from 2007 VICS, Eastern Caribbean Center, University of the Virgin Islands.

Numerator obtained from Office for Highway Safety - 2009 Traffic Data Report.

Notes - 2008
Denominator obtained from 2006 VICS, Eastern Caribbean Center, University of the Virgin Islands.

Numerator obtained from DOH EMS. Numbers represent St.Thomas-St. John District only.

Notes - 2007
Numerator obtained from VI-EMS and Office for Highway Safety, 2007 Pediatric Ambulance Calls / Traffic Safety Facts.

Narrative:
Injuries are the leading cause of death among persons aged 1 through 34 years and a significant health problem affecting the nation's children. About 50 percent of all deaths of children aged 1-14 years are due to injuries, and around 80 percent of these are from motor vehicle crashes. Locally, though data is not reported regarding age and ethnicity, comprehensive information is available from the Office For Highway Safety on traffic related crash data. The data shows a high number of traffic incidents in the territory with a low number of total fatalities.
Data obtained from the VI Office of Highway Safety - Traffic Safety Facts 2009 for these indicators remains consistent. 106 incidents were reported in the 14 years and younger age group with 1 fatality.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	19.2	338.5	441.8	61.7	472.0
Numerator	5	88	114	14	106
Denominator	25996	25996	25805	22697	22458
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Denominator obtained from 2007 VICS, Eastern Caribbean Center, University of the Virgin Islands.

Numerator obtained from Office for Highway Safety - 2009 Traffic Data Report.

Notes - 2008
Denominator obtained from 2006 VICS, Eastern Caribbean Center, University of the Virgin Islands.

Numerator obtained from DOH EMS. Numbers represent St.Thomas-St. John District only.

Notes - 2007

Numerator obtained from VI-EMS and Office for Highway Safety, 2007 Pediatric Ambulance Calls / Traffic Safety Facts.

Narrative:
Injuries are the leading cause of death among persons aged 1 through 34 years and a significant health problem affecting the nation's children. About 50 percent of all deaths of children aged 1-14 years are due to injuries, and around 80 percent of these are from motor vehicle crashes. Locally, though data is not reported regarding age and ethnicity, comprehensive information is available from the Office For Highway Safety on traffic related crash data. The data shows a high number of traffic incidents in the territory with a low number of total fatalities.
Data obtained from the VI Office of Highway Safety - Traffic Safety Facts 2009 for these indicators remains consistent. 106 incidents were reported in the 14 years and younger age group with 1 fatality.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	0.0	1,070.2	1,135.7	71.0	738.4
Numerator	0	153	166	10	104
Denominator	14296	14296	14617	14084	14084
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Denominator obtained from 2007 VICS, Eastern Caribbean Center, University of the Virgin Islands.

Numerator obtained from Office for Highway Safety - 2009 Traffic Data Report.

Notes - 2008
Denominator obtained from 2006 VICS, Eastern Caribbean Center, University of the Virgin Islands.

Numerator obtained from DOH EMS. Numbers represent St.Thomas-St. John District only.

Notes - 2007
Numerator obtained from Office for Highway Safety, 2007 Traffic Safety Facts.

Narrative:
Injuries are the leading cause of death among persons aged 1 through 34 years and a significant health problem affecting the nation's children. About 50 percent of all deaths of children aged 1-14 years are due to injuries, and around 80 percent of these are from motor vehicle crashes. Locally, though data is not reported regarding age and ethnicity, comprehensive information is

available from the Office For Highway Safety on traffic related crash data. The data shows a high number of traffic incidents in the territory with a low number of total fatalities.
Data obtained from the VI Office of Highway Safety - Traffic Safety Facts 2009 for these indicators remains consistent. 104 incidents were reported in this age group.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	24.1	26.6	28.4	39.5	41.2
Numerator	115	127	148	182	162
Denominator	4779	4779	5210	4606	3936
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data for numerator provided from DOH STD/HIV/AIDS/TB Prevention Program for FY 2009. Inclusive of all testing sites in the territory.

Denominator obtained from 2007 VI Community Survey, Eastern Caribbean Center, University of the Virgin Islands.

Notes - 2008
Data provided by VI Family Planning Program FY 2008.

Data provided from DOH STD/HIV/AIDS/TB Prevention Program for FY 2008. Inclusive of all testing sites in the territory.

Narrative:
The Family Planning Program continued their collaboration with the STD Program in the implementation of the Infertility Prevention Project (IPP). An analysis of Chlamydia testing was prepared by Cicatelli Associates, Inc., for the period of CY 2005-2009. Their analysis reveals the need to continue testing and spearhead a prevention/education campaign as positivity rates remains high 23.6% in the adolescent population are most alarming.
The USVI STD Program does the contact tracing of partners of positive clients from all testing sites. All patients and their partners receive appropriate treatment at no cost. All sites provide basic infertility services at Level I and include an initial interview, education, physical examination, counseling, and appropriate referral. In CY 2009 23.6% (162 of 686) of females 15-19 years tested positive. This is a increase from 22.1% in 2008.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	4.3	9.7	8.9	12.6	10.0
Numerator	83	188	152	236	181

Denominator	19370	19370	17117	18664	18168
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data for numerator provided from DOH STD/HIV/AIDS/TB Prevention Program for FY 2009. Inclusive of all testing sites in the territory.

Denominator obtained from 2007 VI Community Survey, Eastern Caribbean Center, University of the Virgin Islands.

Notes - 2008
Data provided by VI Family Planning Program FY 2008.

Data provided from DOH STD/HIV/AIDS/TB Prevention Program for FY 2008. Inclusive of all testing sites in the territory.

Notes - 2007
Denominator obtained from 2005 VI Household Survey, UVI Eastern Caribbean Center. Numerator reflects territorial data reported by the DOH STD/TB/HIV/AIDS Program for CY 2007.

Narrative:
The Family Planning Program continued their collaboration with the STD Program in the implementation of the Infertility Prevention Project (IPP). An analysis of Chlamydia testing was prepared by Cicatelli Associates, Inc., for the period of CY 2005-2009. Their analysis reveals the need to continue testing and spearhead a prevention/education campaign.
The USVI STD Program does the contact tracing of partners of positive clients from all testing sites. All patients and their partners receive appropriate treatment at no cost. All sites provide basic infertility services at Level I and include an initial interview, education, physical examination, counseling, and appropriate referral. In CY 2009 the age group 20-29 showed a average rate of 9.4% in 2009 from 10.5% 2008.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	1755	60	1350	0	5	0	0	340
Children 1 through 4	4054	121	3243	0	0	0	0	690
Children 5 through 9	7440	157	5896	0	0	0	0	1387
Children 10 through 14	9209	420	7652	0	0	0	0	1137
Children 15	8138	220	6985	0	0	0	0	933

through 19								
Children 20 through 24	5677	315	4499	0	0	0	0	863
Children 0 through 24	36273	1293	29625	0	5	0	0	5350

Notes - 2011
Data source: Newborn screening database & newborn nurseries (2) admissions of live births.

Data obtained from VI Community Survey, Eastern Caribbean Center, University of the Virgin Islands.

Narrative:
Population data for this indicator obtained from the 2007 VI Community Survey, UVI Eastern Caribbean Center.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	1438	317	0
Children 1 through 4	3000	1054	0
Children 5 through 9	5798	1642	0
Children 10 through 14	7658	1551	0
Children 15 through 19	6698	1440	0
Children 20 through 24	4390	1287	0
Children 0 through 24	28982	7291	0

Notes - 2011
Data obtained from 2007 VI Community Survey, Eastern Caribbean Center, University of the Virgin Islands.

Narrative:
Population data for this indicator obtained from the 2007 VI Community Survey, UVI Eastern Caribbean Center.

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live	**Total All**	**White**	**Black or African American**	**American Indian or Native**	**Asian**	**Native Hawaiian or Other**	**More than one race reported**	**Other and Unknown**

births	**Races**			**Alaskan**		**Pacific Islander**		
Women < 15	4	0	4	0	0	0	0	0
Women 15 through 17	36	7	28	0	0	0	0	1
Women 18 through 19	83	14	68	0	1	0	0	0
Women 20 through 34	816	179	583	0	43	0	0	11
Women 35 or older	163	36	114	0	11	0	0	2
Women of all ages	1102	236	797	0	55	0	0	14

Notes - 2011

Narrative:
Younger or older mothers, and mothers belonging to racial and/or ethnicity minority groups may be at increased risk of adverse maternal outcomes. Identifying populations of women and their infants at risk, and implementing coordinated systems of pre-conceptual/perinatal services that assures receipt of risk-appropriate health care delivery is essential for healthy mothers and babies.
Due to the time required to receive certificates of live births and thoroughly edit files, the final live birth data for 2009 is not yet available, and may not be available until late fall 2009. Previous experience has shown that preliminary vital statistics estimates made at this time of year (the June after the reporting year) are often inexact. Therefore, vital statistics numbers for 2009 are not used in this narrative. Final data for CY 2008 is provided.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	3	0	1
Women 15 through 17	30	5	1
Women 18 through 19	68	10	5
Women 20 through 34	707	79	30
Women 35 or older	143	15	745
Women of all ages	951	109	782

Notes - 2011

Narrative:
Younger or older mothers, and mothers belonging to racial and/or ethnicity minority groups may be at increased risk of adverse maternal outcomes. Identifying populations of women and their infants at risk, and implementing coordinated systems of pre-conceptual/perinatal services that assures receipt of risk-appropriate health care delivery is essential for healthy mothers and

babies.

Due to the time required to receive certificates of live births and thoroughly edit files, the final live birth data for 2009 is not yet available, and may not be available until late fall 2009. Previous experience has shown that preliminary vital statistics estimates made at this time of year (the June after the reporting year) are often inexact. Therefore, vital statistics numbers for 2009 are not used in this narrative. Final data for CY 2008 is provided.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	6	0	6	0	0	0	0	0
Children 1 through 4	3	1	2	0	0	0	0	0
Children 5 through 9	0	0	0	0	0	0	0	0
Children 10 through 14	2	0	2	0	0	0	0	0
Children 15 through 19	9	2	7	0	0	0	0	0
Children 20 through 24	15	5	10	0	0	0	0	0
Children 0 through 24	35	8	27	0	0	0	0	0

Notes - 2011

Narrative:

The greatest racial and ethnic disparities are seen in the following causes of death in infants: disorders relating to pre-term birth and unspecified low birth weight; respiratory distress syndrome; infections specific to the perinatal period; complications of pregnancy; and sudden infant death syndrome (SIDS). Identifying at-risk populations and implementing and monitoring prevention/intervention programs will play an integral role in eliminating disparities in mortality.

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	6	0	0
Children 1 through 4	3	0	0
Children 5 through 9	0	0	0
Children 10 through 14	2	0	0
Children 15 through	7	2	0

19			
Children 20 through 24	14	1	0
Children 0 through 24	32	3	0

Notes - 2011

Narrative:
The greatest racial and ethnic disparities are seen in the following causes of death in infants: disorders relating to pre-term birth and unspecified low birth weight; respiratory distress syndrome; infections specific to the perinatal period; complications of pregnancy; and sudden infant death syndrome (SIDS). Identifying at-risk populations and implementing and monitoring prevention/intervention programs will play an integral role in eliminating disparities in mortality.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	30598	1111	24689	0	0	0	0	4798	2007
Percent in household headed by single parent	100.0	39.0	58.0	0.0	0.0	0.0	0.0	3.0	2007
Percent in TANF (Grant) families	100.0	10.5	80.0	0.0	0.0	0.0	0.0	9.5	2009
Number enrolled in Medicaid		0	0	0	0	0	0	0	2009
Number enrolled in SCHIP		0	0	0	0	0	0	0	2009
Number living in foster home care		0	0	0	0	0	0	0	2009
Number enrolled in food stamp program	12380	1272	10011	27	13	1	8	1048	2009
Number enrolled in WIC		0	0	0	0	0	0	0	2009
Rate (per 100,000) of juvenile crime arrests	203.0	0.0	182.0	0.0	0.0	0.0	0.0	21.0	2009
Percentage of high school drop-outs (grade 9 through 12)	100.0	0.8	84.0	0.2	0.0	0.0	0.0	15.0	2009

Notes - 2011
Data obtained from 2007 VI COmmunity Survey.

Data obtained from 2007 VI Community Survey and 2009 VI Kids Count Data Book.

Data not available from the Medical Assistance Program (Medicaid).

Data not available from the Medical Assistance Program (Medicaid).

Data not available from the WIC Program.

Data obtained for the VI Police Department, Office for Research and Planning.

Data obtained from VI Department of Educations, Office of Planning, Research and Evaluation for school year 2008-2009.

Data not available from Department of Human Services.

Narrative:
Adverse health outcomes disproportionately affect infants and children in foster care or in single parent homes. The national child poverty rate is reported at 18% in 2007 compared to the VI rate of 34.1%. Children in single parent families are at a higher risk of poverty.
Leaving school before graduation can lead to continued poverty and a higher incidence of juvenile arrests.
Many infants and children eligible for Medicaid and other State programs (e.g. Head Start, Child Care Block Grant Program) are not enrolled. Data linkage of program files with Medicaid may identify factors associated with State program eligibility without full participation.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	24726	5872	0	2007
Percent in household headed by single parent	63.6	36.4	0.0	2007
Percent in TANF (Grant) families	90.5	9.5	0.0	2009
Number enrolled in Medicaid	0	0	0	2009
Number enrolled in SCHIP	0	0	0	2009
Number living in foster home care	0	0	0	2009
Number enrolled in food stamp program	9545	2810	25	2009
Number enrolled in WIC	0	0	0	2009
Rate (per 100,000) of juvenile crime arrests	182.0	21.0	0.0	2009
Percentage of high school drop-outs (grade 9 through 12)	85.2	14.8	0.0	2009

Notes - 2011
Data not available from Medical Assistance Program (Medicaid).

Data not available from Medical Assistance Program (Medicaid).

Data not available from Department of Human Services.

Narrative:
Adverse health outcomes disproportionately affect infants and children in foster care or in single parent homes. The national child poverty rate is reported at 18% in 2007 compared to the VI rate of 34.1%. Children in single parent families are at a higher risk of poverty.
Leaving school before graduation can lead to continued poverty and a higher incidence of juvenile arrests.
Many infants and children eligible for Medicaid and other State programs (e.g. Head Start, Child Care Block Grant Program) are not enrolled. Data linkage of program files with Medicaid may identify factors associated with State program eligibility without full participation.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	0
Living in urban areas	17000
Living in rural areas	17556
Living in frontier areas	0
Total - all children 0 through 19	34556

Notes - 2011

Narrative:
Child health outcomes and the patterns of utilization of health care services can differ greatly by geographic area of living. Poor families living in metropolitan and urban areas without a regular source of coordinated health services may over utilize emergency services or present as frequent walk-ins to community or public health clinics. Access to care for the poor and under-served in rural and frontier areas is largely dependent on the number of providers available and willing to see the uninsured or accept Medicaid or CHIP. Barriers to quality health care may also include inadequate transport to care and ill-equipped health care facilities.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	114744.0
Percent Below: 50% of poverty	28.5
100% of poverty	33.3

200% of poverty	48.3

Notes - 2011

Narrative:
Eligibility for Medicaid, SCHIP and other State programs is in part determined by family income as a percentage of federally defined poverty levels. States have some discretion in determining which groups their Medicaid and SCHIP programs will cover and the financial criteria for Medicaid and SCHIP eligibility.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	30596.0
Percent Below: 50% of poverty	23.8
100% of poverty	29.1
200% of poverty	50.5

Notes - 2011

Narrative:
Eligibility for Medicaid, SCHIP and other State programs is in part determined by family income as a percentage of federally defined poverty levels. States have some discretion in determining which groups their Medicaid and SCHIP programs will cover and the financial criteria for Medicaid and SCHIP eligibility.

F. Other Program Activities

An important part of the Medicaid Program is the Early and Periodic Diagnosis and Treatment (EPSDT) program. EPSDT is designed to provide comprehensive preventive health care services to children from birth to 21 years of age. It also assures that treatment will be provided for problems and conditions identified during screening covered by MAP. The MCH & CSHCN Program is responsible for providing the medical component. Periodicity standards are based on national recommendations for routine child health maintenance. Provision of EPSDT services is a responsibility of the MCH & CSHCN Program and delineated in the MCH-MAP Agreement.

MCH conducted a week long workshop and training session to determine different ways to create both a positive work environment and a healthier community. The focus was on strengthening MCH infrastructure that would enable the program to:
- Provide leadership in the delivery of comprehensive health care for mothers and children in the territory.
- Incorporate evidence-based practices/intervention in the public health system.
- Determine innovative ways to provide comprehensive, family-oriented health care to the women and children in the community given our limited resources.

- Create a more positive work environment

As a result of this workshop, the following occurred:
- A model of comprehensive, more preventative health care system was developed using the Bright Futures model with restructuring of patient flow was developed. This model of care is to be implemented within all the well child clinics as well as the clinics serving children with special health care needs. Once this model is implemented within these clinics, this model will be encouraged to be used by all health care workers providing services to mothers and children within the territory.
- Development of a life course model of health care to be implemented by 2012 within the community health care centers in the territory.
- Creation of a youth ambassador program in which teenagers with certain chronic illnesses form a group/team and not only learn about their illnesses and are encouraged to take on the responsibility of caring for themselves, but are also empowered to become educators about their illness within their schools and their community. The model program at this time is the "MCH Diabetes Youth Ambassador Program". Other Ambassador programs to be developed will be for Sickle Cell, Asthma, and Obesity.
- Development of a Children's Reading Program within the clinics to encourage parents to read, educate and promote proper development of children from a young age. This program will be implemented through a collaborative effort between MCH and several community-based organizations.
- Development of policies and procedures to enhance MCH infrastructure.
- Revision and enhancement of the current home visitation program by implementing certain aspects of the Nurse/Family Program -- with the changes to be implemented in 2012.
- Enhance efforts to improve data collection and collaboration.

By partnering with many of the community based organizations such as VI Perinatal Inc., Inter-Island Parent Coalition for Change, and VI-HUGS, all organizations that provide support services, training information, and resources to parents, health care providers, and schools, outreach efforts were enhanced to educate clients as well as provide family support services. Continuous efforts to educate clients within the clinic setting has improved as evidence-based medicine guidelines are easily accessible via internet linkage to the AAP website and CDC website.

An awareness campaign about Fetal Alcohol Spectrum Disorders (FASD) was launched throughout the community by placing posters/brochures with information about FASD in prenatal clinics, Pediatric Clinics and within the Family Planning Clinics. Within the prenatal clinics, screening efforts were increased by assessing and documenting the amount of alcohol that each pregnant female consumes to identify these pregnancies as high risk pregnancies for FAS. This practice of documenting alcohol use during pregnancy is also done by the Pediatrician who is present at the delivery of the infant as a backup measure to identify high pregnancies for FASD.

G. Technical Assistance

Technical assistance is of immeasurable value in ensuring the systematic, comprehensive, and valid public health approach to needs assessment, information systems development, general systems development, and special issues.

1) The request for technical assistance for survey sample analyses was selected because the program uses several surveys to address the needs of the MCH population including Family Needs Questionnaire, Provider and Client Satisfaction. Data analysis and reporting techniques are not familiar to all staff who could benefit from a training on survey analysis that would include topics such as: setup of data tables, using SPSS to analyze survey data, and preparing analyses and reports.

2) Augment the implementation of a comprehensive Adolescent Healthcare system through

collaboration with national program with success and best practices history.
Compose a representative team of at least 3 members of the MCH/CSHCN Advisory Board and program management to visit an accomplished MCH adolescent program. TA will help further the support for start-up of the VI adolescent service program. The intent is to conduct a demonstration (collaborative) program of six months to one year, in a select location, such a local high school where services will be administered in it entirety. TA will support the framework in which this endeavor will occur.

Overall, it is difficult to develop and implement a sound plan of action that involved access to integrated data on the population MCH/CSHCN serves. This is especially true because the vast majority of statistical data is managed by a broad field of inter and intra-agency sources, and there is formal infrastructure that guides access to State data. Therefore, we have no choice but to seek rapid, alternative measures to alleviate the hardship of acquiring that mandatory, vital information.
Through this request for TA, the VI MCH/CSHCN desire is to collaborate with other National program affiliates to share their methodology and to work through challenges.
New and emerging issues in the delivery of health care to the maternal and child health population demand on-going staff training and education in order to continue to provide current and adequate comprehensive, culturally competent services.

The geographical location of the territory and the high costs of travel to the mainland are barriers to travel for training. Reassessment of staff training needs dictate that technical assistance training in the identified areas should be offered within the territory in order to maximize the benefits obtained.
See the complete Form 15 for the V.I. Technical Assistance request for FY 2011.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	1533492	1512213	1512213		1511960	
2. Unobligated Balance *(Line2, Form 2)*	0	0	0		0	
3. State Funds *(Line3, Form 2)*	1372138	1332435	0		0	
4. Local MCH Funds *(Line4, Form 2)*	0	0	1388966		1255561	
5. Other Funds *(Line5, Form 2)*	0	140000	140000		140000	
6. Program Income *(Line6, Form 2)*	150000	0	0		0	
7. Subtotal	3055630	2984648	3041179		2907521	
8. Other Federal Funds *(Line10, Form 2)*	0	0	0		0	
9. Total *(Line11, Form 2)*	3055630	2984648	3041179		2907521	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2009		FY 2010		FY 2011	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	460048	456177	456177		436128	
b. Infants < 1 year old	460048	456177	456177		436128	
c. Children 1 to 22 years old	914985	907470	912353		872256	
d. Children with	914986	907471	912354		872257	

Special Healthcare Needs						
e. Others	0	0	0		0	
f. Administration	305563	304118	304118		290752	
g. SUBTOTAL	3055630	3031413	3041179		2907521	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	0		0		0	
c. CISS	0		0		0	
d. Abstinence Education	0		0		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	0		0		0	
h. AIDS	0		0		0	
i. CDC	0		0		0	
j. Education	0		0		0	
k. Other						

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	2805630	2805713	2711179		2482521	
II. Enabling Services	50000	35000	50000		125000	
III. Population-Based Services	100000	100000	180000		100000	
IV. Infrastructure Building Services	100000	90700	100000		200000	
V. Federal-State Title V Block Grant Partnership Total	3055630	3031413	3041179		2907521	

A. Expenditures

The request for federal funds is based on OBRA-89 regulations and program priorities. Emphasis is placed on allocating resources to ensure service availability, operational capacity, and the achievement of positive health outcomes. Specific allocations were made to support comprehensive program development and obtain needed personnel to implement the annual plan. This was done within restrictions of the Government of the Virgin Islands budgetary, financial, accounting, procurement, and personnel system. The MCH & CSHCN Program is guided by such government regulations and policies.

The budget for the Maternal Child Health Block Grant was developed by the Program Director, Assistant Director and Territorial Financial Management Coordinator. Specific estimates were requested of program staff responsible for implementing new initiatives. The process of deriving budget estimates was based on the previous fiscal year's actual expenditures and forecasted costs based on the program plan and proposed activities. Due to the assurance role of the MCH & CSHCN Program, funds must be kept available to cover patient care costs. The Title V guideline for the use of funds was adhered to. (Please see Form 2, Form 3, Form 4, and Form 5). Estimates are used in providing budget and expenditure details, while using actual costs for

direct services provision including personnel providing services to children with special needs and subspecialty contracts.

B. Budget

Federal funding through the Title V MCH Block Grant provides needed support to program efforts. There is no funding for special projects anticipated in fiscal year 2011. This status is not expected to change in the near future. An anticipated increase in the state match is budgeted to cover increases negotiated between the local government and employee unions. Local matching funds are used

The Virgin Islands Department of Health budget a total of $2,907,521 for FY 2011. These funds are broken down as follows:

	Amount	Percent
Federal Title V	$1,511,960	52%
State	$1,395,961	48 %

There is a 30/30/10 minimum funding requirement for federal funds. A waiver of this requirement is not requested during this budget year. Of the FY 2011 Federal Title V allocation, the allocations are as follows:

Preventive and Primary Care for Children	$453,588	(30%)
Federal Title V	$680,382	(45%)
Title V Administrative Costs	$151,196	(10%)

Local matching funds include an additional $100,000 for the leasing of clinic space on St. Thomas. The MCH & CSHCN Program in the V.I. does not receive its program income for operating expenses. Clinic revenues are deposited into the Health Revolving Fund from which a portion is appropriated in the subsequent fiscal year.

Funds will pay for personnel costs attributable to program administration for the federally budgeted positions of MCH & CSHCN Director and Assistant Director. These funds will also pay for inter-island travel, training, maintenance of office equipment, administrative office space, and utilities required for the appropriate administration of the program. Funds will be utilized to maintain clean and healthy facilities for all employees and consumers to enter and receive services.

Administrative costs up to 10 percent of the federal allocation will be used to support administrative staff salaries, newspaper announcements, travel for required meetings and conferences both inter-island and on the mainland, office and computer supplies, mailing, internet and postage and AMCHP annual membership dues.

The program does not anticipate any increase in Title V funding this fiscal year. With the anticipated reduction in local funds, the program will remain at or below the same funding levels of previous fiscal years. The program does not receive any funds from the indirect costs paid to the central government.

Program income from third party payors is not allocated back to the program for provision of services to children with special health care needs, expansion of family support and outreach services, or operating expenses. This income would enable the program's ability to plan activities that will address national and state performance measures outcomes.

Direct and Enabling Services

Title V funds will be used to provide preventive and primary care services to women of reproductive age and their infants up to one year of age, children, and youth. The scope of services includes prenatal and high-risk prenatal care, and postpartum care. These funds will be used to support: employment of required medical and clinic staff; needed services not directly

being provided by the program including specialty consultation not available in the territory; equipment and supplies needed by the clinics; outreach activities, and technical assistance for developing a public awareness campaign. Funds will also be used to provide inter-island travel for the Territorial Perinatologist to visit St. Croix on a weekly basis to provide clinical consultation and diagnostic studies such as sonograms and amniocentesis for high-risk prenatal clients.

Funds will be used for provision of services and / or care coordination for children with special health care needs. Clinic services include screening, diagnosis and treatment provided by the following disciplines: pediatrics, nursing, social work, nutrition, audiology, speech pathology, physical and occupational therapy. Funds will be used to support contractual costs to provide on-island specialty clinics in hematology, orthopedics, neurology, cardiology, and off-island services such as endocrinology consultations, and echocardiograms. The program will also pay for uninsured children with special health care needs who may need to travel to Puerto Rico for further medical care not available on island.
Funds are used to purchase hearing aids, audiology molds and supplies as required for children identified with permanent hearing loss up to 21 years of age.

Population Based Services
Funds will be used to conduct public awareness and informational projects; to fund staff for outreach programs; public health awareness campaigns and health promotions activities. These activities include immunizations, oral health education, nutrition related activities and injury prevention.
Funds will be used to support the newborn hearing screening program primarily in the form of dedicated staff time to the project, and purchase of supplies required to perform screening.

Administrative costs for initial newborn metabolic/genetic screening is the responsibility of both hospitals. However, the Title V Program is responsible for follow-up and counseling for all children identified and diagnosed with an inheritable disorder.

Funds will be used to purchase vaccine not available through the Immunization Program for children whose families are insured and not eligible to receive vaccines through the VFC Program.
Infrastructure Building Services
Funding to support the annual meeting of the V.I. Alliance for Primary Care & MCH Advisory Council will be budgeted. Funds will be used to provide staff training and professional development necessary to ensure compliance with national performance measures. Funds will also be used for needs assessment and related activities.
Funds will also be used to provide technology for staff participation in web-casts and teleconferences related to program activities.
All travel expenses required to attend meetings, conferences and trainings in the mainland, and other related activities are paid with these funds.

Maintenance of State Effort
The Virgin Islands Department of Health assures that the level of funding for the MCH & CSHCN Program will be maintained at a level at least equal to that provided during FY'89. Such funding will be provided through direct allocation of local funds and the provision of services to the MCH & CSHCN Program by other departmental programs as in-kind contributions. For FY 2011 funds used to support the leasing of space for the MCH Clinics in St. Thomas are not included to meet the maintenance of state level requirement.

Fair Method of Allocating Funds
A fair method for allocation of Title V funds throughout the Territory has been established by the State agency responsible for the administration of MCH & CSHCN Program. Allotment of Title V funds is based on the needs assessment and is calculated according to:
-Population size served and capacity of each island district; measurements of health status indicators and other data;

-Fixed personnel cost associated with maintaining direct service provision on each island in each of the three service components;
-Costs associated with maintaining support for services in all four levels of the pyramid;
-Coordination with other initiatives and funding streams which supplement, but do not supplant, Title V mandates.

Targeting Funds of Mandated Title V Activities
Funds from the Maternal and Child Health Services Block Grant will be used only to carry out the purpose of Title V programs and activities, consistent with Section 508.

Reasonable Proportion of Funds for Section 501 Purposes
A reasonable proportion of funds will be used to carry out the purposes described in Section 501 (a)(1)(A) through (D) of the Social Security Act. The MCH & CSHCN Program provides direct services in each of the related program components. All charges imposed for the provision of health services are pursuant to a public schedule of charges and adjusted to reflect the income, resources, and family size of individuals receiving the services. In determining ability to pay, a sliding fee scale is used based on the 2009 Federal Poverty Income Guidelines. Low income is defined as 200% of the federal poverty level or below.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

For the detail sheets and objectives for the state performance measures developed from the 2010 needs assessment, refer to TVIS Forms, Form 11 and Form 16 under the section “New State Performance Measure Detail Sheets and Data.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.